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Measuring Social Functioning in Mental Health Studies:

Concepts and Instruments

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Measuring Social Functioning in Mental Health Studies: Concepts and Instruments

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Chapter 1

Introduction and Overview

Social functioning is a broad, general concept, which seems to embrace all human behavior in social roles and contexts. Stripped of jargon, social functioning refers to a person's activities and relationships. But measurement of this or any abstract concept involves simplification; it obscures detail about particular people and circumstances. Instead, measurement applies systematic rules about how information will be grouped to permit comparisons among people and over time. Given the comprehensiveness of the concept, investigators, unsurprisingly, have achieved little consensus about how social functioning should be measured.

Measuring social functioning involves difficult choices even when the task is confined to describing and classifying patterns. This requires decisions about which dimensions to include, items that reflect those dimensions, and ways to define the items operationally. The problem is exacerbated when one tries to identify the presence of approved patterns of social functioning. In the language of DSM-III, these patterns are called "adaptive social functioning." But, designating social functioning as good or bad, adaptive or maladaptive, presupposes normative views about correct social behavior. Either behavior is adaptive because a strong societal consensus exists that approves such behavior and condemns its opposite, or behavior is adaptive because previous research indicates that certain social behavior or activities are associated with perceived well-being. Unfortunately, such a research base is only minimally developed.

Applications of Review

This report is designed to provide a stimulus for the selection of items and scales to measure social functioning in mental health. To that end, the authors developed a theoretical concept of adaptive social functioning. Existing instruments were then collected, critiqued, and compared according to

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their content, the measurement strategy they exemplify, and their psychometric properties. The detailed review of instruments is based on 18 selected measures.

Several potential applications of this work are as follows:

1. Social functioning could be measured in community epidemiological studies of the incidence or prevalence of mental health problems. This would enable comparisons of social functioning among those with and without mental disorders.

2. Social functioning measures could be incorporated into targeted studies of persons identified as having mental health problems. This would permit description of the range of social functioning among those with mental disorders, allow comparison of social functioning according to psychiatric diagnosis, and encourage more precise delineation of the relationship between social and mental functioning.

3. Incorporating social functioning measures into **longitudinal** studies of both general and targeted populations would permit inferences about the effects of mental illness on social functioning.

4. Social functioning measures could be incorporated into casefinding and screening tools. This might be particularly appropriate in primary health care settings.

5. Accepted and reliable measures of social functioning would provide a useful outcome measure for mental health clinicians.

Constraints in Community Epidemiological Studies

This report focuses, first, on the epidemiological uses of a measure of social functioning, and, second, on the screening uses; it only incidentally considers measurement for the evaluation of treatment. The constraints of an epidemiological or screening tool required that social functioning be measured with less time, personal contact, professional observation, and opportunity for verification than one would have in clinical settings.

The difficulties inherent are summarized below:

1. Ordinarily, it would be expected that the information would be gathered directly from the subject, either through a self-report questionnaire or a standardized interview schedule. Interviews would be done by trained lay personnel because psychotherapists in this role would be prohibitively expensive. The opportunities for direct observation would, therefore, be nonexistent or limited. Using family members or friends as proxy respondents would be both impractical and undesirable.

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2. Ordinarily, no background information from existing records would be available. Whatever is to be learned about social functioning would need to be gleaned from information gathered through the questionnaire or interview.

3. One would be forced to select relatively few items to tap the broad domain of social functioning. It was assumed that social functioning items would be appended to a mental health battery and that the whole instrument would need to be kept reasonably short. The importance of reducing respondent burden is greatest when a general population is studied. By contrast, subjects in clinical settings might be motivated to participate out of gratitude or expectation of therapeutic benefit.

4. The subjects would exhibit a wide range of mental functioning. Ideally the instrument should "work" for a variety of diagnoses. Yet, most often, the social functioning measures will be used with persons whose mental disorders are at the less severe end of the continuum. Affective and personality disorders will be heavily represented in general population studies. This would increase the problem of distinguishing operationally between problems in social functioning and mild mental disorder. Mental disorders and problems in social functioning are probably correlated, but measuring social functioning loses its purpose if the concepts are identical.

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Chapter 2

Research Design Issues

Before reviewing and critiquing instruments, the authors considered ways that measures of social functioning might be used in a research design. Early on, two issues that seemed central to the measurement of social functioning in mental health were identified: (1) the implications of treating social functioning as an independent or a dependent variable and (2) the blurring between measures of social support and measures of social functioning.

Independent or Dependent Variable

Over the last decade or so, health care providers have been alerted to the potential importance of the so-called social factors in the etiology, concomitants, and effects of disease, and in response to treatment. For example, oncologists strive to identify social factors associated with developing cancer, social consequences of cancer diagnosis and treatment, and social factors associated with recovery (Milder 1984). Similar inquiries are taking place within other subspecialties (e.g., Wenger et al., in press), and in health care in general. Typically, investigators seek to understand two separate types of relationships: how social factors contribute to disease, help-seeking, and recovery; and how people with various diseases function socially. Therefore, in research design terms, social functioning may either be an independent or a dependent variable.

Mental health practitioners are similarly interested in the social factors associated with developing mental disorders of varying types and severity. Also they are similarly interested in learning about the range of social behavior of people diagnosed as having different types of mental disorders. Again this raises the distinction between independent variable--social functioning associated with developing mental disorders--and dependent variable--social functioning as a result of mental disorders.

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Measurement demands differ somewhat depending on whether social functioning is studied as the independent or dependent variable. When social functioning is an independent variable, investigators may wish to know whether certain conditions of social well-being, such as minimum social involvement, resources for assistance, and so on, are being met. For analytic purposes, it becomes possible to group various types of contacts, activities, and associations into a few measures. For example, a number of measures often considered social functioning are also included in the basic construct of "stressful life events," a literature reviewed here only when it overlapped with social functioning. These life stresses are usually treated as independent variables used to predict physical and mental disorders. When social functioning is a dependent variable, the investigator may wish to capture detail about all pertinent areas of the individual's social functioning, and, therefore, the measure may need to be more comprehensive. This potentially important distinction has been given scant attention in the literature reviewed for this report.

Adaptive Functioning and Social Support

The term "social support" appears frequently in the literature on social functioning. Not only is social support measured in a wide variety of ways, but there is also considerable overlap between measures of adaptive social functioning and measures of social support. These concepts, both important, must be disentangled. Although in an analytic design each could be used as independent or dependent variables, more often social support is an independent and social functioning a dependent variable.

Social functioning as adaptation refers to the way a person meets social expectations and responsibilities. A commonsense approach to adaptive functioning would generate items pertaining to survival in the world (e.g., getting from place to place, having a roof over one's head, communicating, managing tasks of everyday living), fulfilling productive roles (earning a living, not being a financial burden on others or society as a whole), and performing adequately in applicable familial and other roles (e.g., as a parent, a spouse, an adult son or daughter, a neighbor). A measure of adaptation can focus on negative functioning (e.g., unemployment, excessive job instability, arrests, bankruptcies, evictions, or desertion of children are widely regarded as evidence of poor social functioning). Another approach to measurement accentuates the positive and attempts to delineate a continuum of social functioning that includes the upper range of work performance, family role performance, and so on. A second approach to adaptation focuses on personal functioning--i.e., the individual's self-directed behaviors and perceptions about the self in the world.

Social support has been variously defined, but it refers to the way a person is anchored in a social milieu or network so as to receive information, protection, assistance, and a sense of belonging and worth. Social support depends on the behavior of others in the social network as well as the behavior of the focal person. The term social network usually refers to the structural characteristics of a person's family, household, friendships, and

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interactions as a channel for social support, whereas the support itself is the positive effects of network participation.

The two concepts--social functioning and social support--are closely related, yet they should be kept conceptually distinct. A person may conceivably be functioning adaptively yet have a weak social support system--for example, a person who immigrates to the United States alone, or an elderly person with few living friends or relatives. Similarly, a person could be functioning poorly and yet have a strong support system--for example, an unemployed person who meets few obligations but receives money, protection, and affection from a concerned family. Indeed, an extremely poorly functioning person can evoke and consume inordinate amounts of support.

Although this review's major focus is social functioning, items and scales dealing with occupational and role performance embedded in measures of social support were found. Furthermore, the boundaries between the two concepts were imprecise. The person with an absence of social roles may exemplify **both** maladaptive functioning (e.g., social withdrawal) and a weak support system. Also, the place of social skills as a bridge between social functioning and social support needs examination. Superficially, it seems that social functioning is an active idea, whereas social support comes about through a confluence of circumstances. However, as Gottlieb (1983) emphasizes, a person's social behavior may effectively elicit or discourage assistance and support. To that extent, the ability to develop and retain a support system is part of good social functioning.

Table 1 illustrates how social functioning and social support might each be used as independent and dependent variables in community mental health studies. The most usual approach places social support in the independent variable position and social functioning in the dependent variable position. Typically investigators want to know what support systems protect against mental disorders or enhance benefits from treatment. They also want to know how persons with mental disorders function socially. However, as the table illustrates, questions can be posed with the positions of the two variables reversed. Some scholars view social support as intrinsically good (e.g., productive of good morale) and, therefore, would be prone to study social support as an outcome.

Once social functioning and social support are separated conceptually, one can study how the two phenomena are related. For example, one could examine the correlation between type of social functioning and levels and types of social support. Ultimately this might generate information about the kinds of support systems that predict adaptive functioning **despite** mental disorders. In reviewing the literature and instruments, however, it is striking that current concepts and tools are insufficiently sharp to permit these relationships to be studied.

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Table 1. Social functioning/social support as independent/dependent variable

Variable	Social Functioning	Social Support
Independent	What proportion of persons with varying levels of social functioning develop mental illnesses?	What supportive social conditions, relationships or circumstances reduce the risk of mental disorders or predict appropriate use of mental health services?
Dependent	What is the range of social functioning of people with various types of mental disorders? How does psychotherapy affect social functioning?	What supportive social conditions, relationships, and circumstances are found among persons with mental disorders? How does psychotherapy affect social support?

Social Functioning and Mental Diagnosis

In theory, measuring social functioning should be no different when mental health patients are studied than when, say, cancer patients or the general public are studied. However, a study population with mental disorders introduces two kinds of complications. First, social functioning is often used as a basis for a mental health diagnosis. Second, some people with mental disorders are characterized by distorted perceptions and altered moods, which threaten the validity of the information they supply about their social functioning.

DSM-III has added precision to diagnostic nomenclature (American Psychiatric Association 1980). In addition, the Diagnostic Interview Survey (DIS) (Robins et al. 1981) was developed to provide a reliable data collection tool on which a psychiatric diagnosis could be based. The classifications of DSM-III and the questions in the DIS interview show that social functioning is taken into account heavily in reaching diagnostic conclusions. DIS, in particular, contains an extensive section on employment status and employment history, and also collects information about social maladjustment as reflected by arrest records, bad debts, instances of child abuse and other violent behavior, and marital desertion.

Psychological and social indicators are deliberately blended in some measures. An important example is the Global Assessment Scale (GAS) (Endicott et al. 1976). The GAS, a measure of the severity of psychiatric disorders, is designed to indicate both severe mental disorders and positive mental health, using a scoring system from 1-100. (See table 2.) Note that the severity of

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Table 2. Global Assessment Scale

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health-illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30) should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (eg, 35, 58, 63). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

100 | 91	No symptoms, superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity.
90 | 81	Transient symptoms may occur, but good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, "everyday" worries that only occasionally get out of hand.
80 | 71	Minimal symptoms may be present but no more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand.
70 | 61	Some mild symptoms (eg, depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him "sick."
60 | 51	Moderate symptoms OR generally functioning with some difficulty (eg, few friends and flat affect, depressed mood, and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).
50 | 41	Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (eg, suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking).
40 | 31	Major impairment in several areas, such as work, family relations, judgment, thinking, or mood (eg, depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (eg, speech is at times obscure, illogical, or irrelevant), OR single serious suicide attempt.
30 | 21	Unable to function in almost all areas (eg, stays in bed all day), OR behavior is considerably influenced by either delusions or hallucinations, OR serious impairment in communication (eg, sometimes incoherent or unresponsive) or judgment (eg, acts grossly inappropriately).
20 | 11	Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (eg, repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairment in communication (eg, largely incoherent or mute).
10 | 1	Needs constant supervision for several days to prevent hurting self or others, or makes no attempt to maintain minimal personal hygiene.

Source: Body of table from Endicott, J.; Spitzer, R.; Fleiss, J.; and Cohen, J. Global assessment scale: A procedure for measuring overall severity of psychiatric disturbance. Archives of General Psychiatry 33:768, 1976. Copyright 1976 by the American Medical Association. Reprinted by permission of the publisher.

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mental illnesses is, in part, judged by the extent of social impairment. For example, persons scoring in the 51-60 range have moderate symptoms or are functioning with some difficulty (for example, having few friends or engaging in moderately antisocial behavior) whereas those in the 31-40 range will have major mood, judgment, thinking, or social relationship impairments such as neglecting housework and family and avoiding friends, or having made one suicide attempt, or having some impairment in reality testing. Most interesting is that positive mental health is defined almost completely in social terms. Endicott and colleagues write that the two highest intervals, 81-90 and 91-100, are reserved for "those unusually fortunate individuals who are not only without significant psychopathology but also exhibit many traits often referred to as positive mental health, such as superior functioning, a wide range of interests, social effectiveness, warmth, and integrity" (p. 766). There are many ways to reach the same score, and psychological and social indicators are used interchangeably in the anchoring descriptions.

The mingling of the psychological and the social occurs in other instruments, including self-report techniques. An example of the latter is the Brief Self-Assessment Guide (Willer and Miller 1977; Willer and Biggin 1976). This consists of 12 items drawn from a 55-item Self-Assessment Guide. The 12 items, along with information about whether the subject had been hospitalized in the previous year, were highly predictive of admission to a mental hospital. Five of the twelve dichotomously scored items clearly belong in the social domain (i.e., are you friendly with others; have you written or seen any family members; have you had trouble with the law; are you working or, if not, have you looked for a job; and have you had difficulty talking to others?). The other seven items either clearly probe mental disturbances (i.e., attempted or thought about suicide; have been moody and out of control of feeling; have had many headaches; and have repeatedly done senseless things) or are ambiguous (became angry and broke things; found most people uncooperative; was satisfied with self). The time frame for the responses was the past month (or, in another version, the past 3 months).

In more elaborate approaches, psychological and social indicators are also mixed. Frequently, multidimensional measures of "functioning" of the mentally ill will include some psychological and some social dimensions. This review is limited as much as possible either to social functioning measures per se, or to multidimensional measures from which scales pertaining to social functioning could be extracted.

The problem that disordered mental states might affect the validity of responses about social functioning is more difficult to approach. Certainly persons who are delusional, depressed, or experiencing other altered mood states might be likely to report their social contacts and activities inaccurately. Moreover, validation of such material is quite difficult--even if significant others are polled in an attempt to validate the scale, it is by no means certain that the perceptions of relatives constitute an adequate criterion measure. This review sought evidence that the scale constructors had considered this threat to validity and notes any efforts to validate self-report. In general, the more concrete and specific the items, the less likely the possibility the results are influenced by mental states of the respondents, especially considering the types of respondents a community-based study would be likely to tap.

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Chapter 3

Background Work and Concepts

Although it is fair to say that the measurement of adaptive functioning in mental health is in an embryonic state, social functioning and social support have been discussed extensively by scholars in and out of the mental health field. Investigators have also incorporated these concepts into studies, with the operational definitions varying widely. Despite this disarray, there is considerable consensus both about the general dimensions of interest for both social support and social functioning, and about the methodological pitfalls in their measurement.

Adaptive Functioning: The Concept

A useful way of backing into a definition of social functioning is through a typology of social problems. Although not all social problems can be attributed to the fault of individual social functioning, such a listing provides a starting point for consideration. Important work has gone on in the United States and internationally to reach such typologies, and particularly to develop listings of social problems appropriate for use by primary care practitioners. A recent review (Lipkin and Kupka 1982) highlighted the International Classification of Health Problems in Primary Care, the Reason for Visit Classification of the American Medical Records Association (used in the National Ambulatory Care Survey), and an in-progress classification of Reasons for Contact in Primary Care being developed by a World Health Organization Committee, which will have a chapter on Mental and Life Problems. Regier et al. (1982) reviewed the above classifications (which have many features in common) and proposed a new, simpler, but fairly comprehensive classification that might be manageable by primary care personnel. This Proposed Classification of Social Problems specifies 10 major headings (each with examples). (See table 3.)

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Table 3. Proposed classification of social problems

1. **Housing Problems**

   Includes overcrowding, lack of housing, inadequate housing

2. **Change in Residence**

3. **Financial Problems**

   Includes inability to pay bills, debts, or cannot afford sufficient food

4. **Problems in Family**

   a. Conjugal (marital or nonmarital)
   b. Parent-child problems
   c. Family disruption (includes divorce, death)
   d. Other family problems (e.g., with siblings)
   e. Problems caring for sick person (e.g., aged parent)

5. **Other Nonfamily Interpersonal Problem**

   Includes social isolation, death of friend

6. **Educational/Learning Problems**

   a. Educational problems
      Includes school failure, absenteeism, quarrels with teachers, cheating, etc.
   b. Learning problems

7. **Occupational Problems**

   Includes role dissatisfaction, problems at work, unemployment

8. **Legal Problems**

   Includes imprisonment, prosecution, litigation

9. **Personal and Environmental Circumstances Impeding Access to Health Care or Hazardous to Health**

   Includes pollution, transport problems, dysfunctional beliefs, dysfunctional programs

10. **Conflicts With Social or Cultural Institution**

    Includes persecution and conscientious objection

11. **Other**

Source: Abbreviated from Regier et al. 1982.

Deliege (1982) critiques the various classifications of social problems and develops a somewhat different typology, designed to be more universal across cultures and social values. Her general categories of social problems fall in nine areas: food; housing; economic circumstances; family, clan, or community life; home management; employment; education; conditions of life (such as leisure activities); and social and political structures. Most interestingly, she proposed an examination of the nine areas along five subparts: lack, deficit, personal maladjustment, interpersonal relationships,

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and change over time. This raises the question of whether a given area of social functioning (such as work functioning) should be measured in such a way as to distinguish between lack of work, deficient work, maladjustment at work, interpersonal conflict at work, and change in work performance over time. Indeed each of these subparts could spell inadequate functioning in the workplace, yet they reflect quite different aspects.

Identifying the dimensions of social functioning to include in a measure requires moving back and forth between conceptualizing social problem classifications and classifications of social functioning itself. Social role provides a convenient rubric for classifying social functioning. Weissman (1975), whose work in this area has been a benchmark for the field, stated that ordinarily an adult will occupy the following social roles: occupational; marital (as a spouse and a parent); within an extended family (i.e., with parents, siblings, and close relatives); and in the community. Other researchers--both those preceding and following Weissman--tend to identify the same areas subdivided in various ways.

When social role is the organizing theme, investigators face problems in conceptualizing a continuum of desirable performance on the chosen dimensions, or even in determining what lies outside the normal range. Long ago, Barrabee et al. (1955) stated that social adjustment is the degree to which a person fulfills normative social expectations of the behavior that constitutes his roles. Normative social expectations, however, are influenced by the age, education, social class, culture, and abilities of the subject (as well as the beholder who attempts to make the classifications). Some social roles (such as mother and homemaker) are undergoing rapid transition. Normative roles for retirees in their families and in their communities are unsettled in the latter part of the 20th century, as an increasingly healthier, better educated, and more affluent group of 60-year-olds struggles for role definition. Adequate community roles are particularly difficult to define in the positive sense, although agreement can be reached about some aspects of social conduct that have undesirable effects on the safety or well-being of the self or others.

Beyond settling the value-laden questions of how to define adaptive functioning in areas such as employment, marriage, sexual functioning, and so on, one must also consider whether an absolute or a relative standard is needed. Ware (1984) recently pointed out that role functioning is tempered by a person's health status and the demands of the role. Some occupational roles require much less than others in skill, interpersonal relationships, or even energy. Quite objective indicators can be developed in the employment arena--for example, earned income, days away from work, number of employment changes in a specified time--though these are hard to interpret because of the demands of different occupations (in some fields frequent job shifts spell success). One also needs to decide how to handle unemployment when it is endemic in a region or when a person is disabled.

The area of family and interpersonal role functioning poses even more difficulties. The person who chooses to remain unmarried and/or childless has a simplified set of role expectdations to meet. Is that person functioning as well socially as the person with a large family of dependents? What if the single person is also reclusive, avoiding intimate relationships although

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Table 4. Examples for rating of adaptive functioning on axis V of DSM-III

Levels	Adult examples	Child or adolescent examples
1. **SUPERIOR**--Unusually effective functioning in social relations, occupational functioning, and use of leisure time.	Single parent living in deteriorating neighborhood takes excellent care of children and home, has warm relations with friends, and finds time for pursuit of hobby.	A 12-year-old girl gets superior grades in school, is extremely popular among her peers, and excels in many sports. She does all of this with apparent ease and comfort.
2. **VERY GOOD**--Better than average functioning in social relations, occupational functioning, and use of leisure time.	A 65-year-old retired widower does some volunteer work, often sees old friends, and pursues hobbies.	An adolescent boy gets excellent grades, works part-time, has several close friends, and plays banjo in a jazz band. He admits to some distress in "keeping up with everything."
3. **GOOD**--No more than slight impairment in either social or occupational functioning.	A woman with many friends functions extremely well at a difficult job, but says "the strain is too much."	An 8-year-old boy does well in school, has several friends, but bullies younger children.
4. **FAIR**--Moderate impairment in either social relations or occupational functioning, **or** some impairment in both.	A lawyer has trouble carrying through assignments, has several acquaintances, but hardly any close friends.	A 10-year-old girl does poorly in school, but has adequate peer and family relations.
5. **POOR**--Marked impairment in either social relations or occupational functioning, **or** moderate impairment in both.	A man with one or two friends has trouble keeping a job for more than a few weeks.	A 14-year-old boy almost fails in school and has trouble getting along with his peers.

Source: American Psychiatric Association 1980, p. 29.

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meeting responsibilities at work and with parents? Weissman incorporates satisfaction with roles into her formulation of role functioning. Similarly, British investigators Clare and Cairns (1978) approach this problem by introducing three aspects of social functioning in any given topical arena, such as marriage, work, or family relationships: the material situation (objective indicators of performance and opportunity for performance); the management of the role; and the subject's perception of quality. Of course, the question still remains about whether and how this material should be summed into a measure of social functioning.

Perhaps the most widely known conceptualization of social adaptation is the one embodied in the DSM-III; that is, that adaptive functioning is a composite of three areas: occupation functioning, social relationships, and use of leisure time. Diagnosticians are asked to rate the subject's best adaptive functioning during the past year on a 5-point scale from superior to poor, taking all three elements into account with only a few anchoring examples for guidance. (See table 4.) The instructions to the raters do more to illustrate a problem than provide guidance for action. Raters are told that social relations include all relations with people, emphasizing family and friends, and considering both "breadth and quality" of interpersonal relations. Occupation is to include worker, student, and homemaker roles, taking into account the amount, complexity, and quality of the work to be accomplished. The rater is instructed, however, not to rate the person as superior if high occupational functioning is associated with high subjective discomfort. Use of leisure time was to include the depth and range of recreational activities or hobbies and the pleasure derived. Finally, the rater is told that social relations should probably be given greatest weight, and "use of leisure time should affect the overall rating" only "when there is no significant impairment in social relations and occupational functioning or when occupational opportunities are limited or absent."

Although Spitzer and colleagues (Spitzer and Forman 1979; Spitzer et al. 1979) report good interrater reliability for these ratings (based on the pair-tests done on DSM-III in general), the meaning of the information is vague at best. The Structured Clinical Interview for DSM-III (SCID), which is currently under development (Spitzer and Williams 1984), attempts more precision in the adaptive functioning area by separating social and occupation functioning and by asking the client to rate his or her current functioning and best functioning in the last 5 years. The authors recognize, however, that the concept is still defined loosely and leaves much room for subjectivity.

Role functioning as discussed so far has largely been related to social responsibilities; e.g., the responsibility to support a family financially and emotionally if one takes on the role of parent; the responsibility for adults to earn a living; and civic responsibilities as neighbor and community member. However, one could also define adaptive functioning by the kind of behavior associated with happiness. In that case, role performance is no longer the organizing theme. Presumably, normative information could be developed about the patterns of family involvement, use of leisure time, friendships, and so on, that characterize people who feel happy and fulfilled. Indeed, the DSM-III conceptualization includes both adequate role performance and elements that seem to address personal fulfillment. Here one cannot help but get

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bogged down by the infinite variation in patterns of social interaction, the lack of data about the relationship between specific patterns of social functioning and general well-being, and the lack of data about the relationship between satisfaction with social functioning and general well-being.

Another way of looking at social functioning is task-focused. One can examine the performance of or the ability to perform various activities that are prerequisites to independent social life. This method has been specially developed in the field of aging, where combined physical, cognitive, emotional, and social problems may add up to inabilities to perform basic self-care activities (like bathing, toileting, and dressing) or more complex instrumental activities (like housekeeping, using transportation, cooking, and so on). One could incorporate such items into a measure of functional ability meant to be used in mental health studies, emphasizing the Instrumental Activities of Daily Living (IADL) rather than the more basic self-care activities for community surveys. Kane and Kane (1981) described the challenges of making such functional measures on older persons, emphasizing that functional requirements differ according to environmental conditions and social roles. Some people will have no need to perform certain activites (e.g., a wealthy individual may never do yardwork) and some will never have learned the skills (e.g., many men have never learned homemaking skills).

Summarizing the above discussion, it seemed that role functioning, functioning to achieve personal fulfillment, and performance of instrumental tasks should all be a part of a concept of adaptive social functioning. Role functioning should take some precedence (e.g., a person might be quite satisfied with a role as an abusing spouse and it would still be considered maladaptive), yet the concept would be too narrow without consideration of social outlets and the presence of satisfying and varied interactions and activities. However, the latter needs to be approached with caution because there are so few normative data. Perhaps epidemiological studies should simply try to use sensible and clear categories to collect descriptive information about such matters as friendship behavior and use of leisure time.

Social Support: The Concept

Social support has been extensively studied. As with adaptive functioning, the classifications vary from author to author, yet there is underlying agreement. Caplan's seminal work (1974) discussed the social network as mutually supportive aggregates that continuously monitor, reward, and reprimand their members, and, in crisis, help mobilize psychological resources, share tasks, and provide supplies of money, material, tools, skills, and advice among people. Kahn (1979) has deemed supportive transactions that: express positive affects; endorse a person's behavior, perceptions, or views; and provide symbolic or material aid. Barrera (1981) identified five types of support activities: helping people master emotional distress, sharing tasks, giving advice, teaching skills, and providing material aid. In the same vein, Hirsch (1980) mentions five types of support: cognitive guidance, socializing, social reinforcement, tangible assistance,

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and emotional support. Cobb (1976) defined social support as information leading the subject to believe he is cared for, loved, esteemed, valued, and belongs to a network of communication and mutual obligation. Gottlieb (1983) defined social support as consisting of "verbal and/or nonverbal information or advice, tangible aid, or action that is proffered by social intimates or inferred by their presence, and has beneficial effects on the recipient" (p. 29). Cohen and colleagues (in press) divided support into tangible support, appraisal support (meaning support with information and advice), self-esteem support, and belonging support. In a current review of the various combinations in the literature, Wortman (1984) identified six components of social support: acknowledgment of the appropriateness of a person's beliefs, positive affect, encouragement of expression of beliefs and feelings, provision of advice or information, provision of material aid, and indications that a person is a member of a social network.

These definitions highlight that social support comes in both tangible and nontangible forms. It also has an objective and a subjective component, i.e., persons within the subject's network may proffer tangible and nontangible (e.g., advice) help that may or may not be perceived as supportive. One can measure both the objective indicators and the subjective reaction--for example, number of loans received and feelings about those loans. In this regard, Caplan (1971,1972) posited a fourfold division of social support into the possible permutations of tangible/intangible and objective/subjective.

Gottlieb (1983) reviewed ways of measuring social support, finding three categories:

- Embeddedness in a network of social supporters. Social support is seen as a by-product of participation in social aggregates, such as church, clubs, and organizations, as well as the frequency of social contacts in general.

- Participation in dyadic relationships. This approach looks for one or more intimate, mutual relationships from which persons can derive a feeling of being valued and loved.

- Network mobilization. This approach examines patterns of helping transactions, which can be classified broadly in categories such as emotional support, tangible services, cognitive guidance, and so on, or disaggregated into discrete services (has anyone taken you to the doctor; lent you money?).

Some authors claim that the subjective component of support is most important to measure and, in fact, better correlated with positive outcomes than more objective measures (Wortman 1984). A related issue concerns the importance of the quantity of relationships with others, assuming adequate quality. Donald and Ware (1982) have presented evidence that the actual number of relationships may be correlated with well-being and health, whereas Antonucci and Depner (1982) caution against equating number of relationships with support derived. Mueller (1980) points out that because different members of the person's network provide different types of support for different life situations, the studies of supportive networks tend to disagree; some show that the presence of a single family member who provides

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extensive support facilitates adaptation and function, whereas in other contexts a beneficial effect comes from a larger number of persons who are not closely related. Gottlieb (1983) points out that networks can have harmful effects, such as victimizing a person physically or psychologically; inducing unpleasant feelings of indebtedness; providing false reassurance or advice; and exerting excessive, even if well-intentioned, control.

Originally, measures of social support were considered beyond the scope of this review. But an examination of instruments revealed that those purporting to measure social support contained items about social behavior with and toward family and friends that could also be used to measure adaptive functioning. This occurred partly because the two concepts are not always clearly distinguished and partly because they overlap. Moreover, social support can also be said to have a social skill component, just as adaptive functioning has a task performance component. Ability to communicate, to behave in a predictable and acceptable manner, to initiate and sustain relationships--all these influence the likelihood that a person will enjoy a viable support system, however defined operationally. In that sense, the concepts of adaptive functioning and social support merge, because it is surely adaptive to build and retain a support system.

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Chapter 4

Previous Reviews of Instruments

This work is built on previous reviews of instruments. To some extent, each scholar who develops an instrument presents a review of previous instruments in the field and explains why another approach is needed. This kind of information was used both to identify instruments and to become familiar with conceptual approaches. Particular use was also made of several systematic reviews that preceded the present one.

Weissman's two reviews of instruments to measure social adjustment (Weissman 1975; Weissman et al. 1981) were particularly targeted to the present interests. For the final selection, however, many of the measures discussed by Weissman were excluded for one of the following reasons: the instrument depended on a therapist rating, the instrument used a significant other as informant, or the instrument measured only a very narrow aspect of functioning (e.g., conjugal functioning).

Ciarlo's review of instruments to measure the effectiveness of psychotherapy (in press) was a major background resource even though more than half of his selected instruments were inappropriate to the purpose of this report. In addition to reasons already mentioned, many of Ciarlo's instruments concentrated, as might be expected, on psychological variables rather than social variables. Others dealt with social variables but cast the instrument entirely in terms of the helpfulness of the therapist. Despite these caveats, the effort to identify measures useful in documenting the effectiveness of psychotherapy did indeed yield scales or subscales that addressed social functioning directly. In addition, Ciarlo's classification system and logic for review was also helpful. Both the Weissman and Ciarlo reviews also tended to highlight instruments developed for use with severely impaired psychiatric patients.

The Spring 1984 issue of the Community Mental Health Journal was entirely devoted to evaluating community mental health center efforts. This provided a double-check of instruments in use for evaluative purposes. Social functioning is usually a part of such efforts. On the whole, however, the new

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instruments identified through this mechanism were clinical rating scales rather than self-report scales. The Georgia Role Functioning Scale (McPheeters 1984) was the most interesting of the ones examined. It created five scales dealing with these areas: Working/Productivity; Independent Living/Self Care; Immediate Social Network Relationships; Extended Social Network Relationships; and Global Personal Distress (which rated satisfaction with self and others). The conceptualization is helpful though rating scales were beyond the scope of this review.

Many researchers have recently reviewed measurement of social support. One is expecially indebted to Gottlieb (1983), as well as to Wortman (1984); House and Kahn (1984); Wallston et al. (1983); Ell (1984); Donald et al. (1978); and Cohen et al. in press). In contrast to social functioning, which most often seems to have been measured in persons with mental disability, social support has been measured in the general population and among people with a wide array of physical illnesses.

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Chapter 5

Basis for Present Review

The Concepts

For this report, some content categories have been developed and, **a priori**, a list of potential items that might fall under each heading has been generated. Two general categories were chosen and each was further subdivided. For convenience of presentation, the whole subject was divided into Personal Social Functioning and Societal Funct ning. The former included those dimensions of functioning that might pertain to perceived social well-being, regardless of whether expected societal roles were performed. Under the heading of Personal Social Functioning, items that describe a Social Network (Quantitative) and a Social Network (Qualitative) were included. These two headings together embrace most of the items that investigators include under Social Support. A third heading was also included for individual Instrumental Abilities or Social Skills, which, it was recognized, could be called upon in the service of Personal Social Functioning and Societal Functioning. The general heading of Societal Functioning included categories related to role functioning, namely: Work Roles, Family Roles, and the more diffuse category of Societal and Community Roles.

Table 5 shows the hypothesized items listed under six headings. Note the overlap among the categories. For example, in Quantitative Social Network, counts of participation in organizations were included, and in Community Functioning, involvement in membership groups was included. Depending on the intent of the measurer, it is possible to use similar items for both headings. Similarly, relationships with coworkers can fall under Social Network or Work Role, depending on the intention of the measurer. Leisure time activities and organizational affiliations similarly could fit under Social Network or Societal Role. Some instrumental skills, notably homemaking, and child care, fall under Family Roles. It is unclear whether an employed woman's child care arrangements are part of a Work Role or a Family Role, and indeed currently available instruments conceptualize it both ways.

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Table 5. **Conceptual categories for measures of social functioning and items that could be contained in each**

Personal Social Functioning			Societal Functioning		
Social Network (Quantitative)	Social Network (Qualitative)	Instrumental Ability/ Social Skills	Work Roles	Family Roles	Societal/Community Roles
No. friends	Satisfaction with: friends, family, contacts with friends and family, leisure time activities, and social organizations	Cleanliness	Being employed	Spouse (or conjugal partner) role	Organizational participation
No. contacts with friends		Neatness	Employment stability: voluntary change, involuntary change	Conflict	Organizational leadership (could include civic groups, professional groups, recreational groups, church groups)
No. of contacts with family		Ability to transport self	Absenteeism	Satisfaction	
Family contacts out of household, divided into contacts with parents, children, siblings, etc.		Ability to manage finances	Productivity	Time spent together	
		Shopping	Satisfaction with work	Absence of: physical abuse nonsupport	
Time spent with persons in household		Preparing food	Conflict with superiors		Neighbor role
Contact counts divided by in-person, mail, and telephone		Housekeeping	Conflict with co-workers	Parenting Role	Volunteer service
		Handyman work	Job: below training/ education	Conflict	Voting
No. of organizational memberships		Conversational skills	Retirement roles: activity, satisfaction	Satisfaction	Absence of: arrests bankruptcies evictions public disturbances being victimized dropping out of school being fired public dependency
Time spent in organizational functions		Ability to find a doctor if needed	Housewife roles: performance, satisfaction	Skill	
Time spent in various leisure activities		Ability to find a lawyer if needed	Disabled persons: productive activity, satisfaction	Time spent	
		Ability to request help from a stranger		Absence of: child abuse desertion nonsupport	
Duration of friendships		Conformity to norms in appearance, speech, behavior	Income: amount, perceived adequacy, debts		
No. contacts at work		Child care		Family of Origin	Effective use of community resources (e.g., libraries, parks, health and social agencies)
Church membership		Decline in any above abilities		Conflict	
Frequency of religious activity				Dependency	
				Help given to them	
Decline in amount of contact or participation				Help received from them	Spouse or minimal use of organizations connoting dependency (e.g., welfare, soup kitchens, etc.)
Increase in amount of contact or participation				Sexual Functioning	Adequate housing
					Safe environment
				Marital Status	
				Divorce History	

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In part, this model illustrates the difficulty in finding items appropriate to reflect the different areas.

The model also illustrates that the measurer could choose a rather general approach to the topic (clubs and organizations, contacts with family members) or a detailed approach (participation in each of a checklist of clubs, contact with each of a list of specified family members). When the amount of time and, therefore, the number of items, are limited, it seems advantageous to group information together, especially if we expect that certain activities are equivalent (e.g., belonging to a bowling league or a fraternal organization). On the other hand, it is sometimes easier and quicker for a respondent to go down a checklist than to consider an open-ended category, and this might in the long run yield more accurate information than response to a more general set of questions (e.g., how many clubs and organizations do you belong to, how often have you participated in such groups in the last month?).

Measurers should recognize that a change in many of these variables might be as important as the actual value. A precipitous drop in income, reduction or increase in number of contacts, change in satisfaction with role, or loss of social skills would be important to tap. For the most part, one would be interested in decreases rather than increases. However, an increase in contact with relatives could be a sign of crisis just as easily as a sign of social health. Tapping change is a challenge in a cross-sectional study, but it is possible to incorporate questions that do so.

Criteria for Instrument Review

First, selected instruments were examined according to the content areas covered. In terms of content, there was interest in the theoretical justification and logic for including items, the comprehensiveness of content, and the selectivity of content (the latter being almost the opposite of comprehensiveness).

The following were also considered:

Administration and Format--The instruments reviewed varied in method of administration (self-reported questionnaire or interview schedule), length of time required to complete, and complexity of the instrument. Instruments that depended totally on therapist rating, record reviews, clinical interviews, or interviews of persons other than the subject were excluded from the review.

Time Frame--The instruments ranged in time frame from those keyed to the present ("today") to those that used longer intervals such as a month or a year. Quite frequently, especially in longer batteries, the interval varied according to the item measured. Although this might confuse respondents, it is an appropriate strategy because certain infrequent events (e.g., in-person contacts with out-of-town relatives) should be measured with a wider time window than frequently occurring events. An attempt was made to judge whether the time window was appropriate to the variable.

Subjectivity/Objectivity--The extent to which the instrument used objective indicators, subjective indicators, or both was examined.

Change Measures--In keeping with the comments in the preceding section, whether the instrument incorporated a measure of change was examined. There were several ways of doing this: the subject might be asked whether a change had occurred since a specified period (e.g., a year ago) or they could be asked whether changes in their own behavior were brought to their attention (e.g., has anyone told you that you are less friendly than you were a year ago?).

Scoring/Scaling--How information was combined to produce one or more scores was of interest. This involved how items were weighted. Usually all items in a battery were treated equally in scoring, but, of course, the number of items of a particular kind creates a subtle kind of weighting. The scaling that had been done was noted, sometimes according to a theoretical model and sometimes through factor analysis, to identify separate dimensions.

Use History--Note was taken of the populations used to develop the instrument and for its subsequent use. Here several points were of interest: the extent to which the instrument had been tested in the general population and among persons with mental disorders; and the likelihood that the instrument would be useful across sex, age, educational status, and social class.

Reliability--Reliability tests can be of several sorts: internal consistency, test-retest, and interrater. Information about consistency (i.e., alpha reliability) seems most frequently available. The self-report techniques seemed to have been rarely checked for test-retest reliability (without which validity could not be claimed), although sometimes they were later versions of interview formats that had been checked for either interrater reliability or test-retest reliability. Often the interrater reliability tests involved small samples and were based on both raters being at the same interview. Almost always, the analysis of reliability was at the level of a subscale rather than item-by-item.

Validity--Validity is the hardest concept to establish. Most often, authors claimed face validity, and, in those cases, the logic of the assumptions was examined. Concurrent validity was sometimes established by comparing a scale or subscale to some other scale purporting to measure the same thing. In multidimensional batteries, investigators sometimes examined the behavior of the social functioning scales within their own data set to see if the scores correlated with other scales or items in the expected way. Sometimes social functioning measures were validated by their ability to predict depression or other psychiatric disorders, which seems a questionable approach. Finally, investigators sometimes checked the validity of information supplied by the subject by questioning a significant other.

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Choice of Instruments

Some instruments were identified for inspection through previous reviews (e.g., Weissman 1975; Weissman et al. 1981; Ciarlo in press). Other instruments were identified through personal contact with investigators, who sent their questionnaires and interview schedules. (Only instruments that arrived before a specified deadline could be included.) Therefore a few pertinent instruments were missed; however, the goal was not to be encyclopedic but rather to illustrate the range of approaches that have been taken.

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Chapter 6

Instrument Review

Table 6 compares the 18 instruments according to the content included and table 7 compares the same items according to selected criteria. To give a more vivid idea of the variety of approaches, below is included a brief narrative description of each.

The PERI (Psychiatric Epidemiology Research Interview) scales for social functioning (Dohrenwend et al. 1983) would have been included in the table but a copy was not available in time for detailed review. The PERI scales are briefly described in the narrative description.

Community Adaptation Schedule (CAS)

The Community Adaptation Schedule (CAS) (Roen and Burnes 1968) is the oldest of the self-completed questionnaires examined. It contains 217 questions divided into 6 major sections (work, family, social community, larger community, commercial community, and professional community), and 33 subsections. The instrument is notable for its effort to tap a wide range of community functioning: for example, the social community includes friends, neighbors, and people at work; the larger community separates out religion, recreation, organizations and groups, communications, education, moving, and civic community; the commercial community includes items on finances, shopping, transportation, and modern technology; and the professional community section taps adjustment to a range of community services such as social services, and schools. The authors developed a "trimodal" approach--under each of the 33 heads, they included questions designed to elicit the respondent's behavior, affect, and "cognition." All items used 6-point Likert scales. They can be summed by topic or in sub-scales corresponding to each of the three modes.

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Table 6. Comparison of measures of social functioning according to content

Instrument	Personal Functioning Content			Societal Functioning Content		
	Social Network (Quantitative)	Social Network (Qualitative)	Instrumental Abilities/ Social Skills	Work Roles	Family Roles	Community/ Societal Roles
Community Adaptation Schedule (Roen and Burke, 1968)	No. of friends; frequency of contact with family; with friends; with co-workers; participation in clubs and organizations; frequency of church attendance	Numerous items on quality of relationships with spouse; children; parents; other close friends. These tap conflict, ease and depth of communication; help from; feelings about relationships	Financial management (e.g., ability to save, money problems, financial status compared to friends); transportation; household management (how much done; how much done for others; feelings about it)	Feeling good about work; satisfaction with; performance; use of skills (housework abilities as alternative); income (absolute and compared to peers); expectations; relationship of income to expenses	Time spent with children; interest in children; quality of relationship with children; relationship with spouse; sexual functioning; relationship with parents (parental satisfaction with subject)	Participation and attitude to volunteer work; attitudes to police and community services; participation in civic organization, involvement with current events; use of leisure time/recreational activities
Structured and Scaled Interview to Assess Maladjustment (SSIAM) (Gurland et al., 1974)		Qualitative assessment of friendships (e.g., keeping in touch with, loneliness in; hurt by, etc.)	Unconforming in dress; "distressed in other's company"	Lack of interest in work; distress at work	Qualitative questions about family of origin (e.g., dependency on, avoidance); marriage relationship (includes responsibility for child care); sexual functioning	
Social Adjustment Scale (Weissman, Paykel, and Prusoff, n.d.)	No. of friends seen or telephoned in past 2 weeks; no. of times gone out socially with other people; frequency of dating (if applicable)	Ability to discuss feelings openly; arguments with friends; shyness; boredom; loneliness; being hurt by friends; arguments with relatives; help from relatives; avoidance of relatives		Time off work; distress at work; lack of interest	Role of adult child (worry, guilt, dependency); spouse role (dependency, domination vs. submissiveness, sex life); parental role (guilt, worry, amount of involvement)	

Table 6. Comparison of measures of social functioning according to content (continued)

Instrument	Personal Functioning Content			Societal Functioning Content		
	Social Network (Quantitative)	Social Network (Qualitative)	Instrumental Abilities/ Social Skills	Work Roles	Family Roles	Community/ Societal Roles
Standardized Interview to Assess Social Maladjustment (Clare and Cairns, 1978)	Opportunities for interactions with relatives; with neighbors; opportunities for leisure activities, extent of social contacts; extent of leisure activities	Quality of interaction with relatives; with neighbors; satisfaction with above; quality of leisure activities; satisfaction with leisure activities	Household care; housekeeping; management of income; family planning	Family income; occupational stability; opportunities to interest with workmates, quality of interaction; satisfaction with work role, income, and workmates (Special version for housewives, unemployed, disabled or retired)	Child management; quality of domestic household interaction; satisfaction with marital harmony and with sexual compatibility; shared decisionmaking and interests in marriage	Housing conditions; satisfaction with housing; opportunity for, extent of satisfaction with leisure activities
Interview Schedule for Social Interaction (Henderson, Duncan-Jones et al., 1980)	No. of contacts of specified types (with strangers, people one greets, people with shared interests); frequency of social activities with coworkers; no. of nearby close friends; changes in quantity from a year ago; relatives on whom one can depend	For each contact type, perception of whether quantity is adequate; changes in quality from a year ago; items tap intimacy, existence of confidante, and communication reciprocity; need for relationships; loss of relationships and why			Existence of spouse or "single lasting relationship" with whom you "intend sharing your life"	"Anyone dependent on you in their daily life" (could tap a family role as well)
Denver Community Mental Health Center Questionnaire (Ciarlo and Reihman, 1977)	10 items tap household arrangement, Amount of time spent with family in household and family not in household; close friends; no. of close friends; no. of neighbors one speaks to	How much family would help in trouble; how many friends would help in trouble; amount of arguments with friends; amount of physical fights with friends	Proportion of specified tasks done by subject (i.e., financial management; shopping; meal preparation; housekeeping)	Employment status; salary stability; time spent in job training and courses; source of income (taps welfare use)	Proportion of child care done; proportion of discipline done (all, most, some, none)	Alcohol and drug abuse. Items tap quantity/frequency; related social problems (arrests, accidents)

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Table 6. Comparison of measures of social functioning according to content (continued)

Instrument	Personal Functioning Content			Societal Functioning Content		
	Social Network (Quantitative)	Social Network (Qualitative)	Instrumental Abilities/ Social Skills	Work Roles	Family Roles	Community/ Societal Roles
Problems of Everyday Life (Pearlin and Schooler, 1978)	No. of friends; frequency of contact with friends and with relatives; no. of clubs and organizational memberships; extent of organizational activity	Existence of confidante		Employment status; days of work missed; work life now compared to last year; compared to future expectations; compared to peers; retired or nonworking people asked whether seeking work and problems with not working	Marital status; series of questions on spousal relationships; parental role performance (includes time involved, discipline, affection for children, performance) Employed women asked about child care and shared responsibilities	Organizational memberships
Quality of Life (Lehman, 1983)	Frequency of contact with family (in person, phone, mail); frequency of activities with nonfamily in household (i.e., board-and-care home) and out of household (9 items that tap planned activities, dating activities, writing letters, etc.); activities done in past week (list of 16); frequency of religious activity	Existence of close friends; rating of social relationships, pleasure and satisfaction with religious life	Would you know how to contact a doctor if needed; a lawyer; a mental health worker? Could you get to each? Arrange payment?	No. of hours working; feelings about work; source of income; perceived adequacy of income; participation in classes; in sheltered workshop	Marital status	Arrests; victimization; use of leisure time; perception of neighborhood and safety
Multidimensional Assessment Instrument (Lawton et al., 1982)	Visits, no. of phone calls and letters with relatives and with friends; frequency of social and recreational activities (e.g., church, movies, sporting events, etc.)	Existence of confidante; any relatives you feel close to; any friends or neighbors to depend on for help	Telephone use, transportation, shopping, prepare meals, housework, repairs and yardwork; laundry; take medicines; manage money; toileting	Amount of income; perceived adequacy		Victimization (i.e., being a crime victim); satisfaction with neighborhood; feeling safe; volunteer work; voting; leisure time

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Table 6. Comparison of measures of social functioning according to content (continued)

Instrument	Personal Functioning Content			Societal Functioning Content		
	Social Network (Quantitative)	Social Network (Qualitative)	Instrumental Abilities/ Social Skills	Work Roles	Family Roles	Community/ Societal Roles
Health and Daily Living Form (Moos, 1984)	No. friends; no. close friends; frequency of interaction with relatives; with friends (in your homes; outside your home); no. of clubs and organizations you belong to; frequency of attendance of religious service; participation in each of 12 activities with family member; with friends (e.g., picnic, long talk, board game, athletic event)	No. of people subject "can count on;" belonging to "close circle of friends;" causes of family disagreements (checklist)	Household task performance; 13 tasks listed and subject asked who performs them (e.g., bring car for repairs, decides how to spend the money, plans and cooks meals)		Participation in disciplining children, helping children with homework	Club and organization memberships; leisure time
Oregon Quality of Life Questionnaire (Brodsky and Bigelow, 1980)	How much free time spent with close friends last week; how many times had contact by visit, phone or mail with out-of-town friends; how many in household; how much free time spent with household members last week; how many times in contact by visit, phone or mail last month with family members not in household; time spent on leisure and sports; hobbies; television; window-shopping	Ease of making friends; trouble in friendships; perception of whether family would help in a problem; whether friends would help in a problem; whether organizations would help in a problem; desire to share positives with family; with friends	Items on ability to make decisions and deal with conflict (e.g., enter conversations, return merchandise); ability to "get around town;" to get medical care	Employment status; attitudes to work (quality, conflict, interest, absences, etc.); work at school if applicable; work at home; adequacy of income; worry about future income	Spouse role (questions about quality of relationship); parenting role (involvement with children; ability to meet their demands, etc.)	Civic Adjustment Section has questions about range of legal difficulties (being sued, traffic problem, etc.); use of community resources measured by checklist of 39 positive involvements (e.g., museums, churches, community colleges, movies, parks); social and health agencies connoting problems (e.g., welfare, weight-watchers, legal aid, Salvation Army meals); volunteer work

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Table 6. Comparison of measures of social functioning according to content (continued)

Instrument	Personal Functioning Content			Societal Functioning Content		
	Social Network (Quantitative)	Social Network (Qualitative)	Instrumental Abilities/ Social Skills	Work Roles	Family Roles	Community/ Societal Roles
Sickness Impact Profile (Gilson et al., 1978)		Multiple items on social relationships reflecting lessened involvement or enjoyment; less frequent recreational activities	10 home management items reflecting diminished ability to do housework, shopping, paying bills, etc.	Working shorter hours, accomplishing less, and working less accurately than before	Not doing as much child care as usual; not doing as much family care	
Social Health Measure, Rand Health Insurance Study (Donald and Ware, 1982)	No. of neighbors on visiting terms; no. of close friends; frequency of getting together with friends and relatives in past year; frequency of friends visiting in subject's home in past month; visits with friends at their homes; telephone contact with friends and relatives; letters written to friends and relatives; no. of clubs and organizational memberships; frequency of attending religious service	One item: How well are you getting along with people?; Degree of activity in clubs or groups				No. of organizations belonged to; degree of activity in clubs or groups
Social Network Index (Berkman, 1979)	No. of close friends; no. of relatives one feels close to; frequency of contact with these friends and relatives; belonging to a social/recreational group; a union or professional group; a church group; a group concerned with children; a civic group or service club; any other group				Marital status	Organizational participation

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Table 6. Comparison of measures of social functioning according to content (continued)

Instrument	Personal Functioning Content			Societal Functioning Content		
	Social Network (Quantitative)	Social Network (Qualitative)	Instrumental Abilities/ Social Skills	Work Roles	Family Roles	Community/ Societal Roles
Social Support Scale (Lin, Dean, and Easel, 1981)	No. of confidantes of different types and frequency of contact	Yields a scale score on confidantes based on detailed items; a 26-item instrumental-expressive support scale (items probe practical help and emotional support); 4 item family problem scale (e.g., conflict, love, etc.); satisfaction with neighborhood and with community		Satisfaction with work roles; problems managing money (both part of instrumental-affective support scale)	Satisfaction with marital status; with family roles (part of instrumental-affective support scale)	Neighborhood satisfaction; community satisfaction
Inventory of Socially Supportive Behavior (Barrera, Sandler, and Ramsay, 1981)		40 questions that detail the kinds of assistance and support subject had from other people in past month (watching your house, talked about an interest, lent you over $25, told you you were okay, gave you advice, etc.)				
Interpersonal Support Evaluation List (ISEL) (Cohen and Mermelstein, in press)		40 true/false questions tapping 4 areas of support: information and advice; belonging (i.e., quality of interactions with family and friends); tangible support, self-esteem (e.g., someone takes pride in my accomplishments)				
Quality of Life (Saskatchewan) (D'Arcy and Siddique, 1984)	Amount of spare time spent with friends and relatives; organizational membership and participation; frequency of attendance at church	Length of friendships; expectations friends make of you; expectations of relatives	Contribution to family income; responsible for household chores	Stability of job; satisfaction with job	8 items tap relationship with spouse; extent of involvement in child-rearing	Extent of satisfaction with community in 10 areas including social events, safety, schools, health care, authorities

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Table 7. Comparison of selected scales on methodological issues

	Format	Length	Time Frame	Objective vs. Subjective	Scoring/ Scaling	Use History	Reliability	Validity
Community Adaptation Schedule	Self-completed questionnaire	1 hr.	Present or in last wk.	Mixed	Overall score and subscores for behavior, affect, and cognition[1]	Psychiatric inpatients and outpatients; and normal community sample[2]	Test-retest after 1 mo.; correlations for subscales tended to be about .8[2,3]	Construct validity; correlations with California Psychological Inventory (CPI) and Social Activity Inventory[2,4]
Structured and Scaled Interview to Assess Maladjustment (SSIAM)	Semi-structured interview; interviewer rates on basis of answers to questions	30 min.		Subjective items and rater judgment	5 maladjustment scores: work, family, social, marriage, and sex[5]	Adult psychiatric outpatients used as measure of treatment effectiveness	Interrater reliability for intraclass correlation; coefficients = .78-.97; Factors independent[6]	Scores compared with those gathered from significant other interviews ("agreement statistically significant")[6]
Social Adjustment Scale	Semi-structured interview and also a self-report format	3/4 hr. for interview; 15-20 min. for self-report	Present; past 2 wks	Subjective	Subscales: work, social and leisure, extended family, marital, parental, overall adjustment[7]	Depressed persons; psychiatric outpatients; alcoholics; schizophrenics; community sample[7,8,9,10]	Interrater with 31 pairs; 100% agreement in 68% of cases; mean correlation = .83[11]	Ability to discriminate between psychiatric patients and "normals;" sensitivity to change; correlation between interview and self-report ranged from .40 to .76[11]
Standardized Interview to Assess Social Maladjustment	Structured interview; trained interviewers rate responses	est. 45 min.	Present	Mixed	Can yield 3 scores based on aspects of maladjustment that cross content: material conditions; social management; satisfaction. Also can be scored by content dimensions: housing; occupation; economics; leisure/social activities; family/domestic relations; marital[12]	In general practice and social work programs in England; early samples included neurotics and persons with pre-menstrual complaints[13]	Interrater with 4 raters and 48 subjects; good reliability on most items when raters observe same interview; also looked at agreement in extreme item ratings (i.e., 0 for absence of maladjustment and 3 for severe maladjustment). A few items scored poorly[12]	Conscious effort to develop a scale that looks at social functioning independent of psychological functioning; face validity[12]

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Table 7. Comparison of selected scales on methodological issues (continued)

	Format	Length	Time Frame	Objective vs. Subjective	Scoring/ Scaling	Use History	Reliability	Validity
Henderson Interview Schedule for Social Interaction	Semi-structured interview	45 min.	Present	Subjective	Subscales include availability of attachments; adequacy of attachments; availability of social integration; adequacy of social integration; no. unpleasant attachments; no. of attachments not existing and perceived as unneeded[14,15]	Community sample in Canberra, Australia[15]	Test-retest: r's = .51-.79; internal consistency (α's .37-.81); stability high overtime[16]	Face validity; significant score differences between married and unmarried; between newcomers and long-time residents of area[17,18]
Denver Community Mental Health Questionnaire	Structured interview; also self-report format	Est. 30 min. for interview; 15 min. for self-report	Varying time frames from last 24 hrs to last 30 days	Generally subjective	13 analytically derived subscales	Normal community sample, inpatients, outpatients, day care patients and former patients; alcoholics involved[19]	Interrater tests with 6 pairs of raters and 6 subjects; correlations very high (.81-.1)[20,21]	Agreement between client and a collateral person; comparisons; the psychiatric patients differed from "normals" in most dimensions[20,21]
Problems of Everyday Life	Structured interview	Est. 1 hr.	Present; within mo.; some items asked changed since last year		3 scales: life strains (includes marriage, parenting, household, economics, and occupation); stress; and coping efficacy (social resources included)[22]	Random sample of urban Chicago persons aged 18-65 (n = 2300)[23]	α scores = "very good;" test-retest reliability = "quite well established"[24]	Construct (reliability and validity data are unpublished and are unavailable as yet)[24]
Quality of Life	Structured interview	1 hr.	Present; past 2 wks	Mixed	Subscales: objective life domain; subjective life domain[25]	Designed for study of residents of board and care homes[25]	α's for subsections ranged from .44-.89; test-retest = .29-.89; frequency of family contacts most reliable scale[26]	Prediction of global well-being as measured in same study--individual objective indicators accounted for 17% to 77% of variance in global well-being ratings[25]

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Table 7. Comparison of selected scales on methodological issues (continued)

	Format	Length	Time Frame	Objective vs. Subjective	Scoring/ Scaling	Use History	Reliability	Validity
Multidimensional Assessment Instrument	Structured interview	1 hr.	Present; past mo., past yr.	Largely objective	7 domain subscales including personal adjustment; social support; meaningful time use; physical environment, and functional ADL	Elderly subjects in independent living; home care clients; persons on waiting list for facilities	α's .39-9.3 for subsections; test-retest correlations .36-.99 for subsections[27]	MAI domain rating correlated with professional ratings by clinical psychologist and housing administrator with r's ranging from .07-.78[27]
Health and Daily Living Form	Self-administered	45 min.	Past month, past year	Largely objective	4 indices created by sums of yes questions: social activities with friends; social network contacts; no. of close relationships; quality of significant relationships[28]	Depressed patients; community sample; ex-alcoholics[28]	Not available	Not available
Oregon Quality of Life Questionnaire	Self-report		Today, last 3 days, past week, last month		Scales for personal adjustment, interpersonal adjustment, Adjustment to Productivity and Civic Adjustment and many subscales--13 scales in total--norms developed[29]	Psychiatric outpatients; developed for evaluating mental health treatment, used in Oregon and Colorado, and statewide in Tennessee; community "normals"[19]	No test-retest validity; α reliability high[19]	Face validity; comparisons of psychiatric sample with community "normals;" concurrent validity of some subscales with other tests; sensitivity to change with psychiatric treatment[19]
Sickness Impact Profile	Interview or self-completed	20 min.	Present, "today"	Objective	3 relevant subscales (out of 12): namely home management; social interaction; work, and interaction with family	Primary health care users in different diagnostic groups	Test-retest, overall .82, range .51-.93; α's for social interaction factor .79, home management .86, and work .73 and interaction with family .86[30]	Face validity

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Table 7. Comparison of selected scales on methodological issues (continued)

	Format	Length	Time Frame	Objective vs. Subjective	Scoring/ Scaling	Use History	Reliability	Validity
Social Health Measure, Rand Insurance Study	Self-completed (mailed)	11 questions	Present, past mo.	Objective	"Criterion" approach--scale found to be different from other scales on questionnaire and to behave like theoretical model (e.g., be more correlated with mental health scale than physical but different from both)[31]	Community-dwelling adults in large sample in 3 states and 6 locations as part of Rand's Health Insurance Experiment[32]	Internal consistency multiple correlation coefficients .17-.75; item-total correlations .16-.47; stability .23-.66[32]	Face validity; content validity; discriminant validity; construct validity[32]
Social Network Index	Self completed	Brief (originally developed from long questionnaire)	Present	Objective	Developed from items in a larger battery of social items to predict mortality[33,34]	Community sample for longitudinal study in Alameda County, California		Construct, theoretical[33]
Social Support Scale	Structured interview	Est. 1 hr.	Present; past week; past month	Mixed; also interviewer judgment	Instrument used 2 existing instruments: family problem scale; confidante scale; developed 2 items for neighborhood and community satisfaction; and developed a new 26-item instrumental-expressive support scale; the latter yielded 5 factors (monetary problems, lack of companionship, demands, communication problems, and no children)[38]	Community-dwelling adults	Reliability reported in Lin and Dean, 1984, but unclear[39]	Correlation with CES-D; the new instrumental-expressive support scale correlated with family problem scale but applied more widely; construct validity in modeling of the I-E support scale, i.e., the instrumental factors correlated and the affective factors correlated[39]
Inventory of Socially Supportive Behavior	Self-administered (in group situation)	20 min.	Last 4 wks	Objective	Theoretical construct of 4 types of support: tangible, emotional, informational, and self-esteem; however, factor analysis yielded 3 factors	Undergraduate psychology students; pregnant adolescents	Test-retest range .44-.91; α reliability .926 and .940[36]	Correlated with Moos Family Environment Scale and Arizona Social Support Interview Schedule (and faster than latter)[36,37]

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Table 7. Comparison of selected scales on methodological issues (continued)

	Format	Length	Time Frame	Objective vs. Subjective	Scoring/ Scaling	Use History	Reliability	Validity
Interpersonal Support Evaluation List (ISEL)	Self-administered	15 min.	Present	Subjective	Single score	Students; participants in smoking cessation clinics	a reliability .88 to .90 in different studies; test-retest in 2 wks .87 for entire scale[35]	Correlated to Moos Family Environment Scale; Partner Adjustment Scale and Rosenberg Self-Esteem Scale[35]
Quality of Life (Saskatchewan)	Self-completed questionnaire	Est. 20 min.	Present	Mostly subjective	9 item index of spousal support; 11-point scale of community support[40]	Community-dwelling adults in Saskatchewan, Canada[41]	Not available	Spousal and community support items correlated with questions regarding help-seeking behavior[41]

FOOTNOTES

1. Roen and Burnes, 1968
2. Burnes and Roen, 1967
3. Roen et al., 1966
4. Cook and Joseph, 1970
5. Gurland et al., 1972a
6. Gurland et al., 1972b
7. Weissman and Bothwell, 1976
8. Weissman et al., 1978
9. Paykel et al., 1971
10. McCreadie and Barron, 1984
11. Weissman et al., no date
12. Clare and Cairns, 1978
13. Clare and Corney, 1982
14. Duncan-Jones, 1981a
15. Henderson et al., 1981
16. Henderson et al., 1980a
17. Henderson, 1981
18. Henderson et al., 1980b
19. Ciarlo, 1981
20. Ciarlo and Reihman, 1977
21. Butters et al., 1977
22. Pearlin et al., 1981
23. Pearlin and Schooler, 1978
24. Personal communication with L. Pearlin
25. Lehman, 1983
26. Lehman, no date
27. Lawton et al., 1982
28. Moos et al., 1984
29. Brodsky and Bigelow, 1980
30. Gilson et al., 1978
31. Donald et al., 1978
32. Donald and Ware, 1982
33. Berkman, 1977
34. Berkman and Symes, 1979
35. Cohen et al., in press
36. Barrera, 1981
37. Barrera and Ainley, 1983
38. Lin, Dean, and Ensel, 1981
39. Lin and Dean, 1984
40. D'Arcy and Siddique, 1984
41. Syrotuik and D'Arcy, 1982

The CAS is overly complex for a survey approach and somewhat outdated as well. For example, question 115 (for single people only) is "how do you feel about getting married?" The choices range from "like very much" to "dislike very much," and presumably "dislike very much" reflects maladjustment. However, it is still of interest because of the thoroughness with which it approaches community adjustment, mingling questions that tap community awareness (e.g., "Do you know your child(ren)'s teacher?"), sense of public responsibility ("How would you feel about being selected for jury duty?"), comparisons with peers ("Are you as satisfied with your job as others seem to be with theirs?"), and change over time ("How does your previous income compare with your present income?"--much less to much more). The welter of questions is bewildering and the answers would sometimes seem to be uninterpretable, yet anyone interested in community functioning would still find perusal of the items thought-provoking.

The Structured and Scaled Interview to Assess Maladjustment (SSIAM)

Developed by Gurland and colleagues (1972a,b) and dubbed the SSIAM, this is a semistructured interview that assesses social dysfunction in six areas: work, social and leisure life, family of origin, marriage, sex, and overall functioning. It was developed to evaluate the effectiveness of psychiatric treatment in improving a patient's adjustment to the current life situation. Unlike the CAS, which attempts to incorporate positive behavior, attitudes, and perceptions, this instrument is squarely directed at identifying social maladjustment. The SSIAM is administered by a trained interviewer who asks a standardized question and then rates the subject's response by choosing one of a set of response categories. For example, the question is asked "Do you tend to have quarrels and ill-feelings with people at work (for example, supervisors, teachers, co-workers, tradesmen, or clients)?" and, depending on the answer, the interviewer chooses one of these five responses: "definite friction with most work contacts, definite friction with many work contacts, definite friction only with some groups of work contacts, definite friction with only occasional work contact (e.g., a **bete noire**), or relationships reasonably smooth." Allowable probes are also delineated to standardize the interview. For each of the five general areas, the rater is asked to make some inferential rating of the extent to which the other ratings in the area are due to an unfavorable environment and to oversensitivity on the part of the subject. An unfavorable environment is further defined--for example, with family of origin an unfavorable environment includes both geographic distance from the family and the behavior and attitudes of the family.

This instrument would appear to introduce considerable subjectivity because the subject's response is filtered through the judgment of an interviewer. At the least, the interviewers would require substantial training and interviewing aptitude to elicit valid information from the subject. For these reasons, the SSIAM could not be incorporated into a broad-based epidemiological study without great expense. It also leaves areas of community maladjustment uncovered. However, it is of interest as an example of a conceptualization of adjustment that emphasizes subject indicators. For example, in the items on Social and Leisure Life, none of the 10 questions

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probes the frequency, range, and nature of activities, but instead sample questions are: "Are you keeping in touch with friends?, If one of your friends hurts you does it change the way you get on with them or perhaps even with other people?, Do you dress and behave like the others in your own circle?, or Do you have any particular spare time interests and activities?"

The Social Adjustment Scale (SAS)

This instrument, developed by Weissman and colleagues (Paykel et al. 1971) is available in two forms: a semistructured interview version and a self-report questionnaire. The instrument covers work roles, social and leisure roles, family roles (subdivided into extended family, marital family, and parental roles), and financial problems. The self-report version has 54 questions, and subjects are asked to choose the best descriptor of them in the last few weeks. An effort has been made to select quantifiable, objective indicators (e.g., "How many friends have you seen or spoken to on the telephone? How many times in the last two weeks have you gone out socially with other people? Have you had open arguments with your relatives in the last two weeks? How many days of work have you missed in the last two weeks?"). However, other questions seem to tap depressive or anxious feelings directly, and thus overlap with measures of emotion; for example, there are questions about feelings of shame, boredom, loneliness, and worry scattered in the various subscales.

The SAS has been used extensively in studies with depressed patients, other psychiatric outpatients, and general community populations. There are two versions; the interview guide provides a great deal more anchoring descriptions, but the newer self-report format clearly is more useful for the present purposes. Weissman and Bothwell (1976) did a study comparing the two formats, and reported significant agreement.

Standardized Interview to Assess Social Maladjustment[1]

Viewing Weissman's Social Adjustment Scale as "heavily contaminated with psychological features and factors" (Clare and Corney 1982, p. 250), investigators at the Institute of Psychiatry in London, England, developed their own more purely social way of assessing functioning. Like the Gurland technique, a standardized interview format is used, and answers to the

[1]Copies of the instrument can be purchased from Dr. Clare (Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF, England). Orders must be accompanied by a check for 13.82 pounds.

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questions are used to generate ratings. The approach is particularly interesting because it is conceptualized not only along topical dimensions (e.g., housing conditions, occupation, finances, income, marriage, etc.), but also in three cross-cutting modes, rating, for each topical area, the material conditions, the social management of the subject, and the subject's satisfaction. It is thus possible to achieve a summary rating on each of these three cross-cutting themes as well as by topic. Table 8 illustrates the full range of items organized according to the authors' scheme. The instrument has been used to assess the efficacy of general practice and of social work.

Interview Schedule for Social Interaction (ISSI)

Developed in Australia by Henderson and colleagues (Henderson et al. 1980a,b; Henderson et al. 1981; Duncan-Jones 1981a,b), this is a semi-structured interview designed to tap the availability of acquaintances, coworkers, and friends, and the affectional ties existing between the subject and others. Perhaps more than any other instruments in the group, this one probes attachments and social integration. It attempts to estimate the frequency of contacts of specific types (greeting neighbors, speaking to shopkeepers or other impersonal contacts) and of intimate contacts under specified circumstances (e.g., dropping in on friends without notice, number of friends who could drop in on you at dinner without your being embarrassed). There is also an attempt to assess the number of relationships with unpleasant interactions, the number of intimate relationships lost and the reason, and even the relationships an individual "doesn't have and can do without." The time frame is generally the present, but for several questions the respondent is asked about any change from last year. This instrument has been applied in a community study with a large sample in Canberra, Australia.

Denver Community Mental Health Questionnaire (DCMHQ)

The Denver Community Mental Health Questionnaire (Ciarlo and Reihman 1977) is available in its original 79-item semistructured interview format and in a 72-item self-report questionnaire formatted in a booklet suitable for mailing. Designed to measure the effectiveness of mental health treatment with an emphasis on alcohol and drug programs, it has by now been used with a wide variety of patient populations. Most of the content is unsuited to the present purpose, including the items on psychological symptoms, alcohol and substance use, and reactions to psychotherapy. However, the items on relationships with family and friends seem especially useful; they consist of a succinct 11-item battery that, interestingly enough, serve more as indicators of social support than social functioning. Another series of questions probes social activities in and out of the home: these range widely and include some items about work, including "Is your salary different now from what it was three months ago?," as well as items on housekeeping and child care.

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Table 8. Categories and items in the standardized interview to assess social maladjustment

Subject area	Rating category with each item rated shown below the appropriate category		
	Material conditions	Social management	Satisfaction
Housing	Housing conditions*	Household care Management of housekeeping	Satisfaction with housing
Occupational/social role	Occupational stability Opportunities for interaction with workmates*	Quality of personal interaction with workmates	Satisfaction with occupation/social role (includes housewives, unemployed, disabled, retired) Satisfaction with personal interaction with workmates
Economic/social activities	Family income Opportunities for leisure and social activities*	Management of income Extent of leisure and social activities	Satisfaction with income Satisfaction with leisure and social activities.
	Opportunities for interaction with neighbours*	Quality of interaction with neighbours	Satisfaction with interaction with neighbours
			Satisfaction with heterosexual role
Family and domestic relationships	Opportunities for interaction with relatives*	Quality of interaction with relatives	Satisfaction with interaction with relatives
		Quality of solitary living	Satisfaction with solitary living
	Opportunities for domestic interaction (i.e. with unrelated others or adult offspring in household)	Quality of domestic interaction (i.e. with unrelated others or adult offspring in household)	Satisfaction with domestic interaction
	Situational handicaps in child management*	Child management	Satisfaction with parental role
		Fertility and family planning	
Marital		Sharing of responsibilities and decision-making	Satisfaction with marital harmony
		Sharing of interests and activities	Satisfaction with sexual compatibility

* The group of items rates objective restrictions which might be expected to impair functioning in the appropriate area. 'Situational handicaps in child management' assesses difficulties likely to exacerbate normal problems of child-rearing, e.g., inadequate living space, an absent parent. Objective restrictions on leisure activities include extreme age, physical disabilities, heavy domestic or work commitments, isolated situation of the home, etc.

Source: Body of table from Clare, A.W., and Cairns, V.E. Design, development and use of a standardized interview to assess social maladjustment and dysfunction in community studies. Psychological Medicine 8:592, 1978. Copyright 1978 by Cambridge University Press. Reprinted by permission of the publisher.

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Problems of Everyday Life

The Problems of Everyday Life Questionnaire was developed by Pearlin and associates (Pearlin and Schooler 1978; Pearlin et al. 1981) to measure life strain, stress, and coping capacity. It is a structured interview, which has been used in a longitudinal study of the general population, as well as with more specialized groups such as medical students. Life strains have been divided into four areas (marriage, parental, household economics, and occupational) and coping efficacy has been divided into three areas: social resources, psychological resources, and specific coping activities. Little has been published about the scales derived from this instrument, or their reliability and validity.

The present review concerns social functioning, and as yet the word "coping" has been avoided. However, coping **is** social functioning in the presence of stress or social problems. Therefore, one would expect that measures designed to describe coping would also describe social functioning. Indeed, the Pearlin instrument contains series of items on work behavior and attitudes, income, social activities, and parenting activities that are compatible with other instruments reviewed. Other sections tap what this review calls social support--i.e., frequency and type of contact with relatives, friends, and organizations, and the value the subject derives from those contacts. This instrument exemplifies a number of noteworthy strategies:

- The subjects are asked not only to quantify organizational involvement, but to indicate what they "get out of" the organizations on a "yes/no/not sure" checklist that includes religious or spiritual experience, a chance to follow hobbies or special interests, a chance to help other people, a chance to socialize with other people, a chance to learn new things, a chance to get away from day-to-day problems, and things that will help you in your work situation.

- An extensive occupational section probes perceptions about working conditions, income, and interpersonal relationships on the job.

- A section for employed women taps the adequacy of, reactions to, and conflict with spouse about child care arrangements, as well as attitudes to the experience of managing both a job and homemaking.

- A section for nonemployed or retired people examines their preference for working or not working, their job-seeking behavior, income, and problems created by unemployment or retirement. Women who are unemployed or retired are asked an additional set of questions about life as a homemaker.

- A particularly full battery on economic life wherein the family standard of living is measured compared to a year ago, compared to future expectations, and according to ability to purchase specific kinds of items. Income is not only measured directly, but the subject is asked to rate the family income compared to: most of your

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friends, people with an education like you and your husband, most of your relatives, most (black/white) people, and most of your neighbors.

- A detailed appraisal of problems and areas of perceived inadequacy in child-rearing is also included.

The Quality of Life Interview

The Quality of Life Interview (Lehman 1983) was designed for a specific study of social functioning of persons in board-and-care homes. It has not been used in other settings, and many of its questions specifically probe the extent and nature of interactions with other residents of the facility. It is included here because it develops items in some areas not really touched by many other questionnaires--particularly, legal and safety issues (including victimization, and the ability to get help with medical and legal problems). It also contains a useful checklist of leisure time activities, and a few quantitative questions about frequency of contact with family. The occupational and financial questions are designed to be suitable for persons who are unlikely to be fully employed in the competitive workplace or generate income through earnings. This questionnaire combines objective and subjective items in a unique way. The subjective view in each topical area is tapped by asking the respondent to rate how he feels about that aspect of life on a 7-point scale anchored by the words "terrible" and "delighted."

Multi-Level Assessment Instrument (MAI)

The MAI was developed by Lawton and colleagues (1982) at Philadelphia's Geriatric Center to serve as both a research and service-oriented tool. The instrument reflects Lawton's hierarchical model of "competence" (Lawton 1972). Through a 101-question structured interview, competence is systematically assessed in seven areas: the domains of health, activities of daily living, cognition, time use, and social interaction; and the sectors of psychological well-being and perceived environmental quality. A detailed instruction manual is available for users. In addition, a mid-length (67 questions) and a short-length (48 questions) have been developed by statistical identification of the items that were most correlated with each total subscale score.

The MAI is one of several multidimensional assessment instruments designed to measure the functioning of older people. Another well-known technique is the OARS instrument, which gets its acronym from the Older Americans Research and Service Center at Duke. The OARS instrument assesses functioning in five domains (Physical Health, Activities of Daily Living, Mental Health, Social, and Economic). It too is accompanied with detailed information about its use (Duke University 1978). Although the two instruments are similar in many ways, more psychometric work has been done to

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develop the MAI scales; in contrast, the OARS subscales are derived from the interviewers' global ratings of each domain based on answers to the objective questions and anchoring statements. The MAI also contains more environmental items. Therefore the MAI is chosen for review over the OARS to represent an instrument sensitive to the elderly.

The importance of developing measurement tools in mental health that are valid for persons over age 65 is underscored. This is particularly important because of the high prevalence of mental disorders (particularly depression and cognitive impairment) in the elderly, the under-representation of the elderly among those who receive mental health treatment, and the confounding of physical, emotional, cognitive, and social factors in the etiology of the functional problems of older people. In the MAI, some batteries (such as the questions on social activities, social relationships, income, and neighborhood) might be used with younger respondents with little adaptation or addition. The Activities of Daily Living and Instrumental Activities of Daily Living sections were designed to tap abilities that might be compromised by physical or mental impairment, and some items are inappropriate for younger respondents (e.g., toileting difficulties). However, if scales from the MAI were used in community samples of seniors, one could study the effects of mental disorders on the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) when controlling for physical health.

Health and Daily Living (HDL) Form

The Health and Daily Living Form was developed by Moos and colleagues (1984) at the Social Ecology Laboratory, Stanford University. The HDL is a structured assessment procedure that can be administered as an interview or a self-completed questionnaire. It was originally designed to study treatment outcome among alcoholic patients and their families, but also has been used in a study of stress and coping among community married men and women, and in a project examining the rehabilitation of men who had heart attacks. The work was done within a conceptual framework that considered "the personal and environmental determinants of life stressors and the coping and social resources that moderate the effects of such stressors on adaptation." The instrument, therefore, collects information that allowed the authors to develop indices of Life Change Events and Coping Responses. Of particular interest are the Indices of Social Functioning and Resources and the Indices of Family Functioning and Home Environment. In passing, the Index of Negative Life Change Events contains many items that are considered as evidence of maladaptive social functioning (e.g., trouble with friends or neighbors, fired from a job, went deeply into debt, trouble with superiors at work, trouble with in-laws, substantial decrease in income). This reinforces an earlier comment that social functioning used as an independent variable is often formulated to include negative life events.

The section on Social Resources and Activities is compact, yet yields multiple scales. The subject is asked how many friends he has who are more than just casual acquaintances, how many close friends he has, how many people he knows from whom he expects help in times of "real trouble," how many clubs

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and organizations he belongs to, whether he is part of a close circle of friends, and how often he attends religious services. Then a list of 12 activities is presented (e.g., athletic events, board games, concerts, hikes, etc.) and the subject indicates whether he has done any together with a family member and/or together with a friend in the last month. The number of get-togethers with friends and relatives in the last month is also quantified and further divided into get-togethers at your home and outside your home. Finally, for 13 items of domestic activity (e.g., shopping for groceries, heavy housework, handling the bills, tending the yard, helping children with homework) the subject indicates whether during the last month the task was done by "you only, mostly by you, you and others equally, someone else mostly, or someone else entirely." This yields a score on Family Task Sharing (e.g., percentage of applicable tasks the respondent reports sharing equally with someone else), on Tasks Performed by Self, and Tasks Performed by Partner.

An Activities with Friends and an Activities with Families Score is developed by counting affirmative answers on the list of activities done in the past month. (This seems to introduce a value for diversity--for example, a person who went out frequently with friends but concentrated on operas and museums would get a low score whereas a person whose less frequent activities included more of the 12 categories would get a high score.) An Index of Number of Close Relationships is developed by summing the number of close friends and the number of people that can be counted on for real help. Similarly, an Index of Social Network Contacts is developed by summing answers to the number of visits with friends in your home, with relatives in your home, with friends out of your home, and with relatives out of your home, plus the number of organizational memberships.

The HDL shows extensive work in developing scores for what Moos (no date) has called elsewhere "the bloomin', buzzin' confusion of a natural social environment." The investigators have developed some practical approaches. Also, because they have taken the plunge and tried to quantify the area, their work illustrates the way value judgments creep into scoring any social relationships or activities. Note that Moos and his colleagues have also developed various Social Climate Scales, particularly a Family Environment Scale and a Work Environment Scale (both containing 90 true-false questions). These tap the individual's perceptions of their actual and preferred environments, and, though interesting conceptually, are not useful for the present purpose.

Oregon Quality of Life Questionnaire

The Oregon Quality of Life Questionnaire (Brodsky and Bigelow 1980) is a self-report questionnaire developed to look at the outcomes of community mental health programs. It has been used widely in several states. For example, McPheeters (1984) reports on the use of the Tennessee Quality of Life Questionnaire, which was adopted directly and used to measure outcomes statewide.

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The instrument, which is particularly readable and jargon-free, is divided into five large categories of adjustment, and also contains a section on the helpfulness of therapeutic programs. The lengthy Personal Adjustment Section contains 22 items on psychological distress and four on toleration of depression and anxiety. These are not of direct present interest. Also under personal adjustment are nine questions on basic need satisfaction that probe satisfaction with housing, income, transportation, and health care. The subsection on Independence under Personal Adjustment is interesting because it includes items that others might consider as reflecting either social skills or social activities. For example, independence measures include degree of hesitation in joining a conversation at a party; ability to return merchandise; how easy it was last week to shop, pay bills, and prepare meals; and even how many times the person went to social, recreational, or educational events in the past week.

Of greatest interest are the sections on Interpersonal Adjustment, Adjustment to Productivity, and Civic Adjustment. Interpersonal Adjustment measures the Friend Role, the Close Friend Role, the Parent Role, and the Spouse Role (each with five questions that tap conflict, involvement, and pleasure with the particular persons). Social Isolation and Social Support are also measured directly. The Productivity Section measures Work at Home, Work on the Job, Work in School, and Other Productive Activity. The latter not only includes volunteer work, but also leisure time activities such as time spent on hobbies, shopping, recreation and sports, and even "watching really interesting television shows." The Civic Adjustment section was designed with alcohol and drug abuse in mind. However, it contains an interesting checklist that measures Use of Community Resources. The subject indicates his use in the past month of each of about 40 community resources that range from museums, churches, movie theatres, libraries, and community colleges to stigmatized resources such as welfare, food stamps, and soup kitchens and include a wide range of social and health agencies. It is unclear how this information is scored.

The Sickness Impact Profile (SIP)

The Sickness Impact Profile (Bergner et al. 1976; Gilson et al. 1975) is a multidimensional instrument designed to assess health status as an outcome measure of the effectiveness of health care. It covers a broad range of dimensions within the following 14 categories of items:

A. Social Interaction
C. Sleep and Rest
D. Taking Nutrition
E. Usual Daily Work
F. Household Management
G. Mobility/Confinement
H. Movement of the Body
J. Pastimes and Recreation
K. Intellectual Function
L. Family Interaction
M. Emotions, Sensations
N. Personal Hygiene

Items were culled from the literature and nominated by providers, consumers, and researchers until an exhaustive list was generated. Testing

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resulted in a revised SIP as 235 questions. A short form with 146 questions is also available. The questionnaire is in true-false form, and respondents are asked to check as true only statements that "you are sure describe you today and are related to your state of health." If SIP questions were to be modified for community mental health studies, the reference to health status would need to be eliminated from the instructions. In that case, some of the scales are pertinent to social functioning, especially the ones on Social Interaction, Usual Daily Work, Household Management, Communication, Pastimes and Recreation, and Family Interaction. Considerable work has been done to develop subscales with equal-appearing intervals.

Because the approach is designed to measure outcomes related to ill-health and health care, many of the items are cast in terms of change from a previous state. This can be illustrated by the examples of items below:

(From Pastimes and Recreation)

I do my hobbies and recreation for shorter periods of time.
I am doing fewer community activities.

(From Usual Daily Work)

I am not accomplishing as much as usual at work.
I am working shorter hours.
I do not do my job as carefully and accurately as usual.

(From Social Interaction)

I am going out less to visit people.
I am cutting down the length of visits with friends.
I talk less with those around me.

The Rand Social Health Measure

In the early 1970s The Rand Corporation was funded to conduct a large-scale experiment on the effects of health insurance on health care utilization and health status. The study, which used a random sample of households in six localities in three States, employed mailed questionnaires as one source of annual longitudinal data on the health status of all enrollees. Health status was construed broadly, and separate scales were constructed to measure health in terms of physical functioning, mental health, social health, and health perceptions. (See Brook et al. 1979a,b for an overview of how health was conceptualized and measured.)

The Rand Social Health Measure taps a wide range of social activities: the frequency of telephone contacts with friends and family, the frequency of letter-writing to friends or family, the frequency with which the respondent goes out with friends and the frequency with which the respondent receives friends at home. Other items tap the quantity and quality of relationships: the number of close friends and the extent of discord in relationships ("How

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well are you getting along with other people these days--better than usual, about the same, or not as well as usual?") The Rand Social Health Measure also taps the number of voluntary groups affiliated with, and the respondent's extent of involvement within the groups. The instrument is economical, consisting of 11 questions, most of which are quantified.

Social Network Index

This Index proved to be a predictor of mortality in the longitudinal community-based epidemiological study done in Alameda County, California (Berkman 1977; Berkman and Breslow 1983; Berkman and Syme 1979). In that study, the subjects were asked a number of questions about their social and political activities, group memberships, and friendships. Specifically, they checked whether they belonged to these kinds of groups: a social or recreational group; a labor union or professional association; a church group; a group concerned with children such as a PTA or Boy Scout Group; a group concerned with community betterment, charity, or service; and any other group. They were also asked to indicate the number of their close friends, the number of relatives they feel close to, and the number of these friends and relatives seen at least once a month (all three questions had five fixed response categories ranging from 0 to 10 or more). These three questions about contacts were combined with marital status to construct a Contact With Intimates Index as follows:

High = married + high friends and relatives score

Medium = married + medium friends and relatives score
OR
= unmarried + high friends and relatives score

Low = married + low friends and relatives score
OR
= unmarried + low and medium friends and relatives score

The Contact With Intimates Scores (high, medium, and low) were then combined with the information about group membership to construct the Social Network Index itself. These membership items were perceived as indicators of Extended Ties, and church membership was given more weighting than any of the other involvements. This led to a Social Network Index that ranged from I-IV and was constructed according to table 9. As the table illustrates, contacts with intimates were judged more important than extended ties, so that a person could have the highest Social Network Score with no extended ties at all, if the intimate ties were at the highest level.

This index would clearly serve as a measure of social support rather than social functioning. It is of interest because of its simplicity and its apparent ability to work in predicting mortality.

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Table 9. Construction of the Berkman Social Network Index

Extended ties	Contacts with intimates		
	High	Medium	Low
Church + other group	IV	IV	II
Church only	IV	III	II
Group only	IV	III	II
Neither	IV	II	I

Asher (1984) recently reported a more elaborate Social Support Index, which he developed based on the Berkman Index. He theorized that the association between Social Network and mortality comes about because the social network is the primary source of a person's information about diseases, warning signs of illness, the quality of medical care, and methods of preventive care. His model continues to give more weight to family contacts than to organizational contacts but it is more elaborated as shown below:

Number of persons in household _____
Number of parents living but not with respondent _____
Number of spouse's parents living but not with respondent __
Number of children not living with respondent _____
Number of siblings living _____
Number of spouse's siblings living _____

Contact with: parents, spouse's parents, children not living at home, siblings, other relatives, and friends (for each of these 6 categories, 10 points if once weekly or more, 5 if once monthly or less, and 0 if no contact).

Number of professional and social organizations belonged to (0 if none, 5 if 1-2, 2 if 3-5, 3 if 6 or more).
Number of trips to barber shop and Number of Spouse's trips to beauty shop (for each, 1 if once monthly or less, 2 if more than once monthly, 0 if never).

The points for the contact questions are summed with the actual numbers for the first six questions to create the index.

Social Support Scale

A very different and more subjective approach to measuring social support is found in this instrument, developed by Lin and colleagues at the State University of New York at Albany (Lin et al. 1981; Lin and Dean 1984). The authors combined elements from existing questionnaires (specifically the

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Medalie-Goldbourt Family Problems items and Lowenthal-Haven-Kaplan confidante items), with two straightforward items that probed neighborhood satisfaction and community satisfaction, and their own 26-item Instrumental-Affective Support Scale. It is the latter battery that is of particular interest.

Respondents were given a list of problems "that people sometimes have" and, using the last 6 months as a reference point, were asked how much they were bothered by the problems (on a 4-point scale from "most or all of the time" to "rarely or none of the time").

The problem list was as follows:

1. Having problems managing money.
2. Not having a close companion.
3. Having too many responsibilities.
4. Not having people you can depend on.
5. Too many demands on your time.
6. Not having a satisfactory sex life.
7. Having problems communicating with others.
8. Not seeing enough of people you feel close to.
9. Deciding on how to spend your money.
10. Not having enough responsibilities.
11. Having too little leisure time.
12. Not having enough money to do the things you want.
13. Problems with children.
14. Not having a satisfying job.
15. Feeling too controlled by others.
16. Not having enough money to get by on.
17. Dissatisfied with marital status.
18. Not having enough close friends.
19. Problems with spouse/ex-spouse.
20. Not having someone who shows you love and affection.
21. Feeling too dependent on others.
22. Not having children.
23. Problems with in-laws or relatives.
24. Not having someone who understands your problems.
25. Having too much time on your hands.
26. Conflicts with people who are close to you.

The authors derived four aspects of social support from their analyses: monetary problems, demands, not enough responsibility, and too controlled by others. A fifth element, community and neighborhood satisfaction, was based on the two questions that directly probed those areas.

Inventory of Socially Supportive Behaviors (ISSB)

The Inventory of Socially Supportive Behaviors (Barrera 1981) illustrates a particularly interesting approach to measuring social support. Barrera conceptualized social support as containing the following dimensions: directive guidance, nondirectional support, positive social interaction, and

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tangible assistance. The Inventory consists of 40 questions, posed in the form of: "During the past four weeks, how often did other people do these activities for you, to you, or with you?" Examples:

Looked after a family member when you were away.
Gave you over $25.
Agreed that what you wanted to do was right.
Taught you how to do something.
Told you you were okay just the way you are.

The responses are quantified on a 5-point scale ranging from "not at all" to "about every day."

The Inventory of Socially Supportive Behaviors correlates well with the Arizona Social Support Interview Schedule (ASSIS), which is being refined concurrently. The ASSIS recognized six areas of social support: private feelings, material aid, advice, positive feedback, physical assistance, and social participation. The respondent is first asked for each area to give the names or initials of any persons who could give that kind of support (e.g., people you could talk about private feelings with; people who you know would lend you $25 or more; people you know would let you know if they liked your ideas, etc.). They were then asked whether that type of support **actually** occurred during the month, their need for that type of support during the month, and their satisfaction with the transactions. The respondents were finally asked whether they had any unpleasant arguments or encounters that made them upset with any of the mentioned people during the month. It was permissible to name the same people more than once for different support areas. The ASSIS yields three measures of network size: the available network, the utilized network (both from unduplicated counts of names), and the unconflicted network (subtracting those that have been associated with conflict).

Both the ASSIS and the Inventory of Socially Supportive Behaviors have been used primarily with pregnant adolescents. Only the Inventory appears in the summary tables.

Interpersonal Support Evaluation List (ISEL)

The ISEL was developed to measure social support in a variety of health settings. It contains 40 probably true-probably false questions, 10 for each of four dimensions of social support: appraisal (meaning receipt of feedback and advice), belonging, tangible, and self esteem. A few examples from each area:

Appraisal:

There is one person whose advice I really trust.
There is someone I could turn to for advice about changing my job or finding a new one.

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Belonging:

If I wanted to have lunch with someone, I could easily find someone to join me.
No one I know would throw a birthday party for me.

Tangible:

If I needed a quick loan of $100, there is someone I could get it from.
There is no one I could call on if I needed to borrow a car for a few hours.

Self-Esteem:

Most of my friends are more interesting than I am.
In general, people don't have much confidence in me.
I have someone who takes pride in my accomplishments.

Quality of Life (Saskatchewan)

The Psychiatric Research Division of the University of Saskatchewan has been conducting a line of research on the well-being of the general population in the province (D'Arcy 1982; Syrotuik and D'Arcy 1984) and specific subgroups, such as mothers of preschool or school-age children (D'Arcy and Siddique 1984) and schoolteachers (Syrotuik and D'Arcy 1984). The authors developed two distinct indexes of social support--spousal support and community support. The former probes compatibility and satisfaction with the spouse in terms of emotional, sexual, and shared activity areas in nine questions, each answered on a 10-point scale. The Community Support Index elicits satisfaction with ten specified areas of community life, again on a 10-point scale. The general question is: "How satisfied are you with your community (city, town, village) in the following areas?," and the listed areas are: social events, cultural activities, recreational facilities, safety, media available, schools, health care, authorities (i.e., police, town council, etc.), shopping, and roads and transportation. The last index is a particularly interesting approach to gauging a person's sense of being part of a supportive community. However, the authors found that spousal support was more correlated with psychiatric well-being than community support, which played a secondary role.

The PERI Social Functioning Scales (PERI)

Dohrenwend et al. (1983) report that they included measures of social functioning in the PERI (Psychiatric Epidemiology Research Interview) and strived to keep these distinct from psychologic functioning measures (not available for inclusion in tables 6 and 7) that were designed to describe

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functioning in work, marriage, and parenting. The conceptualization seemed particularly interesting because the authors separated attainment measures (whether the person was occupying a preferred status, such as being employed or being married), the performance in that status, and satisfaction with the role. The PERI social functioning measures have been used in Jerusalem as well as New York City.

The narrative description of the Jerusalem PERI social functioning measures depicts them as containing nine measures: job attainment (2 items), job performance (10 items), job satisfaction (3 items), housework (6 items), and parental satisfaction (8 items). Job attainment measured the extent of employment in the previous year for all those not full-time homemakers. Marital attainment described whether a person is currently married, excluding single persons under 30. The validity of the scales was tested in part by comparing a total community sample to a sample of psychiatric patients. The latter fared worse on all the dimensions except job performance, leading the authors to question that scale.

The PERI scales are available from Bruce Dohrenwend at Columbia University.

Chapter 7

Summary

General Observations

This review of measures of social functioning reveals that an impressive amount of work has gone into the construction of instruments; moreover, substantial agreement exists on the dimensions of the phenomena that are important to measure. If the introduction of "social" measures in epidemiological studies were to be encouraged, ample models are available from which to develop an instrument. However, it is doubtful that any of the measures reviewed here can be adopted **in toto** as the complete tool for the purpose.

From this review of the state-of-the-art, a number of general observations and caveats can be made:

1. In reviewing social functioning measures, the authors frequently encountered three other concepts which sometimes were embedded in the very instruments examined: life events, stresses, and coping. Social functioning measures are readily confounded with life events measures, and these are often combined within the same questionnaire. Generally, batteries of life events measures include many events that could in part be attributed to the functioning of the focal person (e.g., fights, arrests, being fired, disturbances with neighbors) as well as those that have no reference to the focal person (e.g., deaths, illnesses, catastrophic disasters). Similarly, measures of stressors often include items pertaining to social functioning. Finally, measures of coping also deal with functioning--some coping measures are subjective or highly oriented to problem-solving strategies but others deal with objective activities and subjective experience of the social network.

2. The distinctions between social functioning and social support blur somewhat in actual applications. One might say that the person who achieves for himself a support group willing to provide goods, services, admiration,

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and love is functioning well and exercising social skills compared to the person who elicits none of that assistance. The concepts "social functioning" and "social support" are also linked because a minimum amount of social interaction and activity is a prerequisite to satisfactory social functioning, and too much isolation puts the individual at psychological and physical risk. Quantitative measures of social network definitely deal with this concept.

3. Value judgments pervade measures of social functioning. This is inevitable because adequacy of role performance is at issue. Special care is therefore needed to examine the various scales for applicability across age, sex, and culture.

4. The unsettled and rapidly changing role of women in the United States complicates the measurement of social functioning, and the available instruments reflect that uncertainty. Sometimes women are asked homemaker questions in lieu of occupational questions if they indicate they are not working out of the home; this strategy underestimates a poor occupational adjustment among those women who prefer to work and/or were educated to work. Similarly parental and household responsibility measures sometimes examine the extent to which activities are shared with another adult rather than done alone. Such a measure seems predicated on the false norm of the two-parent household.

5. Measures of instrumental skills necessary for functioning seem scarce. They are abundantly available in third-person rating formats for assessing the skills of regressed persons, but are not as evident in self-report formats. Oddly enough, the best such measures have been developed as measures of Instrumental Activities of Daily Living (IADL) for the elderly; these have potential to be adapted for a general population.

6. Measures of social skills in the sense of the ability to converse, interact, dress, and generally comport oneself **appropriately** compared to social norms are underdeveloped. Some examples were encountered of efforts to measure it directly through asking the respondent whether he seemed to be different from others, whether he experienced difficulties in starting conversations, and so on.

7. There has been much more attention given to elaborating spousal roles and parental roles with minor children than to other family roles. Moreover, the spouse roles are viewed in terms of the child-rearing period. Much less attention has been given to measuring social roles of single persons, of adults in relation to their aging parents, or of the elderly either as single or married persons.

8. The issue of reciprocity arises with the measures of family role functioning and even relationships with friends. Measures of social support usually try to determine whether mutuality exists in the relationships. This follows from a conceptual framework which requires that a fully supported person receive respect and affection from interactions with others. However, when functional abilities as a spouse or parent are being measured, it is not always clear why reciprocity is an important concept.

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9. In many instances, items have been combined into scales in ways that do not seem logically defensible. For example, activities combined in a checklist to illustrate social participation may include solitary activities like going to the movies, taking walks, or watching television. Another frequent strategy is to make an additive scale based on the number of different types of activities pursued. In such a strategy, a person would get a higher score for having gone to a baseball game, a concert, a club meeting, and a party in the past month than a person who had only gone to concerts or played bridge, regardless of the frequency of the latter events. Yet logic dictates that satisfying social patterns are most often based on just a few engrossing interests. Similarly, some approaches would score higher contact with many types of people (relatives, friends, neighbors) in many contexts (your home, theirs) than frequent contacts with fewer persons in fewer settings.

10. Terms were too often undefined. For example, people might be asked to indicate how many organizations they belong to with few clues about the definition of organization or membership provided. (What should be counted? Is paying dues equivalent to attending meetings?) Similarly, terms like conflict, money problems, and so on are sometimes left vague. Leaving "conflict" undefined recognizes that the perception of conflict may be more important than the actual nature of the encounter. However, the obstacle is that the information thus gained is uninterpretable except in terms of perceptions. Some investigators solve the problem of lack of specificity with checklists; others provide careful definitional statements. Both approaches are endorsed.

11. Most instruments contained many items on satisfaction, perceived quality of life, and so on. This emphasis in measuring social functioning is of dubious value. Surely behavior is the essence of social functioning, whereas perceptions come closer to mental states.

General Recommendations

A few general recommendations are offered for next steps in refining measures of social functioning for use in community mental health surveys.

1. Distinguishing between social functioning and social support is critical. One should be conceptually clear about whether the purpose is to measure the adequacy of the subject's functioning in terms of role performance, social behavior, and social skills compared to measuring the adequacy of the person's embeddedness in a network that provides assistance, advice, emotional nurturance, and other commodities deemed supportive.

2. Thresholds of performance, activity or relationships that would seem important for any person's well-being must be developed. Then the measurement could examine that extent to which the threshold is reached, rather than attempt to capture the range and variety of human behavior. This seems particularly true for measures of interaction and activity, where the concern is that the person who is pronounced as functioning adequately has at least a

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minimum of social involvement, opportunity to exchange confidences, and social stimulation.

3. In the areas of performance, it seems productive to probe for negative behaviors or situations. The presence of arrests, debts, financial dependency, evictions, public disturbances, conflict with neighbors, nonsupport of children, and similar items would seem good proxies for maladaptation. Especially in the early stages of using social functioning measures, measures should emphasize maladaptation in work and family roles rather than positive performance, always taking care that the questions are not offensive to respondents.

4. Items should be as objective and specific as possible. When a short time window is imposed (e.g., in the last few weeks), it is feasible for respondents to answer quantitative questions about encounters, contacts, and events. Less frequently occurring events measured over a longer time frame (e.g., a year) are probably sufficiently memorable to be quantified as well. When subjectivity is introduced, it is still helpful to anchor the question by a clear description of the type of perception or reaction being probed (e.g., how often at work did you feel that you were disliked by coworkers--not how often do you feel people don't like you).

5. Simple descriptive indicators of social functioning should be included, particularly because basic information is not yet available about the relationship of mental functioning to certain objective social parameters. Particularly when longitudinal studies are undertaken, it seems useful to ask directly about changes in marital status, divorce history, income, household composition, employment stablity, number of minor children, and so on. It would seem a shame to develop elaborate scales and neglect the obvious.

Choosing a screening tool for a primary care setting, which was a secondary interest of this review, imposes a different set of constraints than choosing measures for community surveys. Clinical settings provide a greater opportunity for validating the subject's responses and generating indepth information. The social history and the physical examination clearly provide opportunities that would be absent in a community-based epidemiological study. On the other hand, the effects of medical illnesses may temporarily bias the information about social functioning gathered from surveys in primary care settings. Thus the time frame tapped by the items would need to be carefully considered.

In general, screening items for use in primary care should be chosen because of their likelihood to represent the phenomenon being screened for. If the rationale for the screening is to alert the general practitioner to social problems that might have a psychological etiology or that might interact with medical problems and their treatment, then the instrument's items should be selected accordingly. Also, in all likelihood more items dealing with satisfaction, with care and other such subjective indicators would be desirable in this context than in an epidemiological survey. Designing a screening tool is beyond the scope of this review, nor is it a practical exercise without a specific care context in mind.

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Perhaps the most important reason for screening social functioning in a primary care setting is to (1) influence the thinking of the physicians and (2) remind them of areas of inquiry that might be important. In that case, the point is not to achieve a quantifiable measure of social well-being, but to efficiently and accurately bring social factors to the forefront of medical practice. The choice between a checklist approach to be completed in an interview with the patient or a self-completed questionnaire to be filled out regularly would be made on pragmatic grounds, depending on the volume of persons using the setting, and the likelihood that private matters would be more comfortably disclosed on a questionnaire or in an interview. The latter is a testable proposition. Although this review did not include a systematic search of the literature on the use of social functioning measures in primary care, there has been some preliminary work on the subject (Jencks 1985; Clare and Corney 1982). This is an area ripe for practical testing. Such testing should look both at the mechanics of securing reliable and valid data, and the way social information of various kinds actually changes or fails to change the behavior of physicians.

Toward A Survey Tool

This report concludes with an admittedly subjective statement about an ideal minimum data set on adaptive social functioning, and the extent to which the instruments surveyed appear promising for yielding some of the desired items.

The minimum data set proposed incorporates two of the principles just outlined: the importance of determining whether the person is functioning beyond an acceptable threshold, and the importance of ascertaining the absence of functioning that is clearly maladaptive in the sense of unmet responsibilities. Using the headings already developed for this report, some minimum data elements under each heading could be envisaged.

The social network should be measured quantitatively to ensure that a person has at least some minimum amount of interaction and activity. Complete social isolation surely constitutes inadequate social functioning. A variety of scales seem to approach this acceptably by querying the frequency of personal and telephone contacts with others, and the frequency of attendance of a variety of activities.

The social network probably should also be measured qualitatively in a minimum sense. It seems important, for example, that the well-functioning individual have at least one friend in whom he can confide, and that he have some sense of having somewhere to turn for practical assistance in a crisis.

Regarding instrumental activities and social skills, it seems important to measure whether the person is able to do basic survival tasks such as managing money, getting about the community, maintaining a household, communicating appropriately, dressing appropriately, and so on. With no capacity to observe these matters directly, the survey needs to be ingenious

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to pick up on the appropriateness of social behavior, although it is more straightforward to measure the performance of various tasks.

Work roles might best be measured to determine whether a person holds a job, has reasonable job stability, earning power consistent with his training, and is not on a downward trajectory--i.e., working and earning below capacity. Clearly such a measure must take cognizance of retired persons, students, and others in transitional states. It is not necessary to replace these questions for a retired person with questions about household work or volunteer work if the major purpose of this set of items is to see if those whom society expects to function as workers are doing so.

In the area of family roles, one is also seeking information about the extent to which the individual fulfills what is expected in roles voluntarily undertaken such as spouse or parent. First, one expects no abuse of spouse or minor children, and certainly nonsupport of minor children would seem to be reflective of inadequate functioning. It also seems reasonable to measure the conflict in such relationships and to expect that the amount of conflict not exceed an established threshold. With reference to family of origin, one would ordinarily expect an adult to have some contact with parents and siblings (assuming they are living) and this minimum relatedness could be measured. At the opposite end of the spectrum is undue dependence on the judgment and assistance of relatives, and this also might be worth examining.

Finally, societal and community functioning could also be examined in terms of a person's ability to exist in the community without violating its clear norms (i.e., through disturbances, conflict with neighbors, arrests, debts, evictions, and so on). In a more positive vein, it is possible to measure civic involvement and general sense of belonging to and participation in one's community, and this too could be examined in terms of an acceptable threshold.

Table 10 reviews the instruments again in terms of their ability to yield this kind of information about social functioning. The table includes judgment of the extent to which each instrument covers the minimum social functioning information recommended. The numeral "1" has been used when the items in a given instrument might be used essentially intact and a "2" when the items approach an important area but need more intensive work to be useful in the targeted context.

Modifications might entail changing the wording or the focus of items, or including additional items that tap other aspects of the particular dimension of social functioning being examined. For example, the SIP contained items that seemed promising as a brief measure of work roles; however, the SIP was developed as a measure of the impact of sickness, and the questions would need to be changed to present a more general focus of the work **per se**. Nevertheless the SIP was rated as a "2" for its work related questions because they were intrinsically interesting. To take another example, the Interview Schedule for Social Interaction (ISSI) could be adapted for measuring the quantitative and qualitative aspects of the social network, but additional items would be needed to specify family relationships (e.g., sibling, parent, child) and items would be needed on time spent in and satisfaction with leisure activities. It might also be necessary to shorten the instrument

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Table 10. Review of selected instruments[a] according to dimensions recommended for further consideration

	CAS	SSIAM	SAS	ISSI	DCMHQ	Pearlin	Lehman	MAI (OARS)	Moos	OREGON	SIP	RAND	Berkman Index	Lin & Dean	ISSB (ASSIS)	ISEL	SASK.
Network (Quantitative)			1[b]	2[c]	2			1 (1)	2	1		1	1		(2)		
Network (Qualitative)		2	2	2				1 (1)						2	2 (2)	2	
IADL					2	2		1 (1)									
Social Skills							2			1							
Work Roles	2	2	2			2				1	2						
Family Roles	2	2				2											
Societal Roles	2						2			2							2

[a]The Clare Standardized Interview to Assess Social Maladjustment is not included in table due to lack of access to actual instrument.

Legend: [b]1 means that items may be able to be used intact.
[c]2 means that items are interesting but modifications would be needed for community study.

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somewhat to reduce respondent burden (especially because new items would be needed to tap the full domain). Generally speaking, a "1" is used when it was judged that a scale could be applied "as is," and a "2" when it seemed more tinkering would be needed, perhaps because the original had been developed in a specific context for a specific study.

Rating instruments is clearly a subjective exercise--others might have a different set of positive and negative reactions, even using the present criteria on the ideal content for each dimension. Therefore, the table is offered with some temerity. It would have been preferable to conclude this review by pointing to **the** instrument that should be used in epidemiological studies to measure social functioning. Unfortunately, a single instrument that combines an economical, objective, and comprehensive approach has not been identified.

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